State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Tune 3 2004 ear **Physician** 12:15p Pettit Roger /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death Examiner Montgomery 3616 Littledale Road Kensington 8. Date of Birth (Month, Day, Year) May 7,1918 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 XM 2 ☐ F 042-14-7202 86 Yrs. Brookln, NY Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County or 28a-f show the Medical Examiner must be notified at Md Montgomery 1 ☐ Yes 2X No Kensington Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20895 3616 Littledale Road 23a USA Funerai 12. Was Decedent Ever in U.S. Armed Forces?

1 🖫 Yes 2 🗆 No 194

If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1941 filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ White 1 Yes 2 No Specify: δ 3 XWidowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Sales Training Retail permit. Pages 1 and 2 should be filed w
Department of Health and Mental Hygier
Important: If them 27 is marked other th
any injury or other traumatic event, Its
once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Russell B.Pettit Vera Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1923 Bright Leaf Ct. Silver Spring, Md20902 Faith Shah/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crem. 6/04/04 Beltsville, MD ¹ 4 □ Donation/ 5 ☐ Other (Specify) runeral Service License, 21. Signature PHT1Tpdogs Afthaldi Funeral Service, P.A. 9241 Columbia Blvd.Silver Spring, MD20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastano Concer colon **Physician** /Medical Due to (or as a consequence of): Examiner er toneal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit everative that initiated events resulting in death) Last and Due to (or as/a consequence of): Box 68760, Medical Certification; To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypercholestendenne 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No 2**X** No To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (1771) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 🔀 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier June 4,2004 10 who completed cause of death (Item 23a) (Type, Print) Ajay Reddy MD. 6320 Democracy Blvd. Bethesda, MD 20817 31. Date filed (Month) Da 32. Registrar's Signature State 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar AMEND#26penMD6/8/04,BMW,MbCb Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician DONE 1253M -RANCIS 2004 June 2 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Easton Hospita albot Memorial If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Months Days Hours Year) 1**⊠**M 2□F Director 23, 577-40-1022 1932 Washington, Jan. Usuel Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits oriant: If Itam 27 is marked other than "natural; or Itams 23a or 28a-f show in ury or other traumatic event, the Medical Evantinst must be notified at 1 ☐ Yes 2 🖾 No Directo Maryland Talbot Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29730 Charles Drive 21601 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Amed Forces:

1 Myes 2 No
If yes, Give Korean
Year or Dates: Conflict Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Steam Fitter Contractor permit Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked othe any in ury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Francis L. Poore Virginia L. Hynson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29730 Charles Drive, Easton, MD 21601 Elizabeth A. Poore/ Wife timore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State June 7, 1 Burial 2 Cremation 3 Removal from State Crest Lawn Memorial 4 ☐ Donation 5 ☐ Other (Specify) Marriotsville, Maryland 2004 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licenses Wille 500 University Blvd. W., Silver Spring, MD 20901
enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) IDIOPATHIC **Physician** IMONIARY UTWI /Medical Due to (or as a consequence of) **Examiner** UMPULL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a cons sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) the attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Be Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home Hospital: Certification: To 1 Inpatient 2 ER/Outpatient IN DOA After this 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 18 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

20+

31. Date filed (Month, Day, Year) JUN 0 8 2004

1 AC

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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		-	For State Registrar	State of M	aryland / D		rtment of H ificate of I		nd Me		giene Reg. No.		
			Decedent's Name (First, Middle, Last)						2	2. Date of Da		004	3. Time of Death
	Physicia		ROSE R. PURZITSKY						J	Month UNE 2,	200	Year 4	12:17 PM
	/Medic Examin	al	4a. Facility Name (If not institution, give s	treet and number)			4b. City, Town, or	Location of	Death		4c. (County of Death	1
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	Funeral		5. Social Security Number 6. Sex	7. Ag	ge (In yrs. last birti 81	rhday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min.	3. Date of Bir (Month, Da	th y, Year)	Co	nplace (State or Foreign untry)
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	and and		10a. State 10b. County		10c. City, Town	or Loc	ation						10d. Inside City Limits
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	within 72 hours after death with the Maryland liene. Ithen "natural", or items 23s or 28s-f show the Madical Examination notified at	Funeral		2. Was Decedent Armed Forces	Ever in U.S.	13. W	as Decedent of H Yes, specify Cuba	spanic Origin n, Mexican,	in? (Spec Puerto R	ify Yes or No ican, etc.)	- 1	4. Race - Amei Black, White	
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	and 2 saith a n 27 is		NORMAN PURZITSKY/SO	ON				AVE.,		-			RIO, CANADA
Dalimore,	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	cemeter	f Dispos ry, crem	ition (Name of atory or other plac	:e)	Da	ite	20c. Lo	cation - City or	Town, State
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0	permit. Pages Department of I Important: If ite any injury or a	1	21. Signature of Funeral Service License	(h) / .		DA	Name and Addre	ss of Facility GOLDBI	ERG N	MEMORIA	AL CH	IAPELS,	INC.
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Division	or Attendii after death. Director: A	Certification:	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of I	njury - At home, fa	arm, stre		0.35%		8f. Location	Street an	d Number or Ru	ıral Route Number,
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	To the within To the comp	Me	29b. Signature and title of certifier	7			29c. Licen:				29d. Dat	e signed (Mont	h, Day, Year)
-	3		1 unus	hul	372		1)	360	27		JUN	E 3, 20	04
	_		30. Name and address of person who co										
			DR. THOMAS MILITAN		CARROLL	AVE	., TAKOM	A PARK	, MD	20912			
	C+	ate	31. Date liled (Month, Day, Year)		strar's Signature	1	1	,					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended 15.,6/9/04,LDB,DOR Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 12:15 PM 2004 TMan June /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Cambridg Dorchester Hospita. General Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Days Feb. 11, 1940 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State it of Health and Mental Hygiene.
If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Exercities from the action of the traumatic event, the Medical Exercities from the action of the formal actions and the action of the formal actions are actions. 1 Nes 2 No Completed by Funeral Director Dorchester 10g. Citizen of What Country? 10e. Street and Number Street 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 2 1 No Baltimore, Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Poultry roduction ine Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pittman Mae Ennals ena harles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Internal 19b. Mailing Address (Street a 21613 Sarah Kane 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 0 Cambridge Waugh Cemetery permit. Page Department of Important: If any injury or once. 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility
HENRY FUNERAL Home, P. A. 21. Signature of Funeral Service Licenses 510 Washington St. Cambridge, MD Part1. Enfer the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardionyo Dilated ear Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. the attending physician ned for use as the buria Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Month in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 1 No 1 🗌 Yes 1 Yes 2 No Division of Vital Hospital or Attending Physician: filled in by the funeral director, 26. Place of Death Check only one Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA 1 Dinpatient 2 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. To the Hospital or Attendi within 24 hours after death.
To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 47924 6.2-04

State Registrar 30. Name and address of person who co

31. Date filed (Month, Gay Year)

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AURURA

CAMRRIDGE

STREET

MD 21613

npleted cause of death (Item 23a) (Type, Print)

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9 2004 32. Resistrar's Signature

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 29 2004 Eleanor Harris Robinson May 9:35 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Homewood Retirement Center Washington Williamsport If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) May 23,1916 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🔀 F 88 Yrs Maryland 217-12-2173 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State or Items 23a or 28a-f ahow f Health and Mental Hygiene item 27 is marked other than "natural", or items 23a or 28a-f ahov other traumatic event, the Macaral Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo MD Washington Williamsport 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21795 United States 16505 Virginia Avenue Completed by Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🙀 No Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Aircraft Industry Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be finance and Mental File marked of Harris Issac Hiedwohl Nellie Spicer McDonald ۵ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6808 Collins Dale Road Baltimore, MD 21234 Mary M. Dils/Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 0 = 0 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State June 4,2004 Hagerstown, Maryland permit. Page Department of Important: If any injury or once. Rest Haven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility Gerald N.Minnich Funeral Home 21. Signature of Paneral Service 305 N. Potomac Street, Hagerstown, MD 21740 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Discase or Injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of) Physician/Medical attending p IF FEMALE: 981 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy 1 Live birth Year Month in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed? 280 No certificate 1 ☐ Yes Division of Vital To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: P 1 ☐ Yes 2 No 3 DOA 2 ER/Outpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? completely filled in by the funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Medical Certification: After 5 Pending Injury 1)X Natural 2 Accident 1 ☐ Yes 2 ☐ No death. investigation Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifies 29c. License number and address of person who completed cause of death (Item 23a) (Type, Print) strar's Signature 31. Date filed (Month State JUN 0 2 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 20°0°4 TINE: 5:47P ELIZABETH LOUISE ROWEN 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death FREDERICK Filader 1 Year | If Under 24 Hrs. MEMORIAL HOSPITAL FREDERICK FREDERICK 8. Date of Birth (Month, Day, Year) March 10,1916 9. Birthplace (State or Foreign Country) Washington D.C. 1 Year Days 7. Age (In yrs. last birthday) 5 Social Security Number Hours 1□M 21 F 88 578-24-1531 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 1 Yes 2 □ No Maryland Frederick Frederick 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 21701 United States 110 Burgess Hill Way Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No Specify Specify 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Clerk Typist Fort Detrick 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Emilline M. Zimmerman / friend 6906 Greenvale Court Frederick, Maryland 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Frederick Crematory 6/7/2004 Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral Homes P.A. 21. Signature of Funeral Service Licensee 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) UROSEPSIS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 Yes 2 No 5 🗆 Other (specify) 4☐Pregnant at time of death 9 Unknown

Pnysician /Medical Examiner

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Physician

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Funeral Director

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Examiner

Funeral

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1 and 2 should be filed within 72 hours efter deeth with the Maryland Health and Mental Hygiene. em 27 is marked other then "natural", or items 23a or 28a-f ehow

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Division of Vital Records,

item 27 is marked other then "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at

Examiner requires that the death certificate be executed burial-transit and attending physicien Physician/Medical the detached þ Completed To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certification properties of the funeral director. Be 7 Certification:

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Part II. Other significant conditions	contributing to death but not resulting	g in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Inknown
			24a. Was an autopsy performed? 1 ☐ Yes 2 No
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examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 ER/	Outpatient 3 DOA Other: 4 Nursin	g Home 5 ☐ Residence 6 ☐ Other (Specify)
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			ace, and due to the cause(s) and manner as stated. ccurred at the time, date and place, and due to the cause(s)
29b. Signature and title of certifier		29c. License number	29d. Date signed (Month, Day, Year)

State Registrar

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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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29b. Signature and title of certifier

HEMEN

65-6

Johnson DR. Thomas

D006041

6.3.2004 FREDERICK

32. Registrar's Signature 2004

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Willard Baltimore, M	permit. Pages 1 and 2 should Department of Health and Men Important: If itam 27 Is marke any injury or other traumatic. 2008.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 1 □ Donation 5 □ Other (Specify	Removal from State	20b. Place of Dispo Scarpelli Fu	sition (Name of natory or other place) neral Home, PA		c. Location - City or Town, State Cresaptown MD
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Yeer Month **Physician** :30 AM Helen Regina Rotruck 29,2004 MAY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ALLEGANY CUMBERLAND HUSPITAL SACRED HEART 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🛣 F 74 217-30-1349 06/14/1929 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental hygiene. Important: If Item 27 te marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be collided at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No Completed by Funeral Director Allegany LaVale 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 36 LaVale Boulevard 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Nidowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Elizabeth Loretta 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sharon E. Derlan /daughter 1602 Frederick Street, Cumberland, MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1XX Burial 2 Cremation 3 Removal from State St. Mary's Cemetery 06/02/2004 Cumberland, MD 4 □Donation 5 □Other (Specify) 22. Name and Address of Facility Mams Family Funeral Home, P.A. 21. Signature of Juneral Service Licens 404 Decatur Street, Cumberland, MD 21502 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition CEREBROVASCULAR Physician resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an this certificate has 2 No 1 Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 No 3□ DOA 2 ER/Outpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide Fo the Hospitel 29a. Certifier 🞾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5 - 29 - 2004 MDD2337 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 625 ALE CUMBERLAND W 21502 ZAMAN WAMLAR 32. Registrar's Signature 31. Date filed (Month, Day, Year) State ouks JUN 0 1 2004 Registrar

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Marylai		rtificate of L		-	Reg. No _{ch}	0.01	0.0
and .	Dissolution		1. Decedent's Name (First, Middle, Last)		-			2. Date of De Month	ath Day	() () Ls Year	3. Time of Death
3	Physicia /Medic		Ovetta Lyle					June 9		004	9:49 P M
>	Examin	er	4a. Facility Name (If not institution, give st				Location of Death		4c. C	ounty of Death	
		a,	3333 University B1 5. Social Security Number 6. Sex		. last birthday)	Kensing		8. Date of Bir	th	Montgo	
ß.	Funeral Director		299-26-5205	м 2ДXF 72		Months Days	Hours Min.	July 6.	ıy, Year)		place (State or Foreign ntry) Dama
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation					10d. Inside City Limits
	Manyi if sho	ŏ	Marriand Montgom	0.201	Vone	idnatan					1 □Yes 2 XNo
	1 the	Director	Maryland Montgom 10e. Street and Number	era	Kens	ington 10f. Zip Code			10g. Citize	n of What Cou	ntry?
	3a o		3333 University Bl	vd. #504			20895			U.S.A.	
	deat	Funeral		Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H If Yes, specify Cuba	spanic Origin? (Sp	pecify Yes or No Rican, etc.)		Race - Ameri Black, White,	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland hal Hygiene. do other than "natural", or Items 23a or 28e-f show event, the Medical Exert must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ※ Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:	,			lack
Ŏ	72 ho	Completed by	15. Decedent's Educ (Specify only highest grade	ation	16a. Dece	dent's Usual Occupa	ation during most of work	ana	16b. Kind	of Business/Ir	ndustry
21	ithin	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)				
7	e filed within Il Hygiene. other than vent, the Me		12		Med	lia Assist	ant 18. Mother's Nam	o (First Middle		lic Sch	nools
gug	be fill	Be	17. Father's Name (First, Middle, Last)						, Maidell Si	umame)	
2	nould be d Mental narked o	2	William Lyles 19a. Informant's Name/Relationship (Type	on Print)	10h Maili	ng Address (Street a		Lyles	er City or 1	Town State 7ii	n Code)
Mai	d 2 st th and 7 Is r traur		Edward T. Rhodes			Connection			-		
	ss 1 and 2 should bof Health and Ment litem 27 is marked rother traumatic errother erro		20a. Method of Disposition	20h	Place of Disno	sition (Name of		Date	20c Loca	ation - City or T	own State
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot		1 ☐ Burial 2 【 Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	oudon F	Park Crema	Jun.2	0,2004	Balt	imore,	Maryland
Bai	Depar Impor any in		21 Signature of Funeral Service License) Aos ()						Home, Inc. g, MD 20904
ę.			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the dea e cause on each line.	ath. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
,	Physician		Immediate Cause (Final disease or condition	METASTATIC	CANCE	R PRIMAR	Y UNKNO	N			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse							
	LAGITITICI	_	Sequentially list conditions, b	Due to (or as a conse	auence of):						
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Box	eath certi attending I for use a		IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fe		⊒Ectopic pregnancy			23	d. Date of deliv	rery
	death	Physician/M	in the past 12 months? 1 Yes 2 No	4☐ Pregnant at time of		Other (specify)				Month	Day Year
P.0	that the dended by the a	hy	9 □ Unknown					T			
of Vital Records, I	86 50	by	Part II. Other significant conditions con	tributing to death but not re	sulting in the u	inderlying cause giv	en in Part I.	23e. Did 1			the cause of death? bably 4 □Unknown
O	w require been si should I	Completed						24a. Was		24b. Were auto	opsy findings available
Re	The lay	m o						auto perio	psy ormed? 2 \(\sqrt{No} \)	death?	ompletion of cause of
tal		0	25. Was case referred to medical				26. Place of Dea				
Ž	(r) =	To B	examiner? 1 ☐ Yes 2 ☑ No	ospital: 1 Inpatient 2	☐ ER/Outpatie	nt 3 DOA Oth	er: 4 Nursing H	ome 5 Mesi	dence 6	Other (Speci	fy)
			27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. Injury Wor		28d. Describe	how injury	occurred	
io io	uttendir death. ctor: Al y the fu	atle	2 Accident investigation			M 1 🗆	Yes 2 ☐ No				
Division	afor Attanding Phy after death. I Diractor: After this d in by the funeral of	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, st cify)	reet, factory, offica		28f. Location (City or To		Number or Run	al Route Number,
	To the Hospital or Attanding within 24 hours after death. To the Funeral Diractor: Attencompletely filled in by the fune	Medical C	29a. Certifier 1 Certifying Physical Check only 2 Medical Examination	sician: To the best of my kiner. On the basis of examinand manner stated.	nowledge, deat nation and/or in	th occurred at the tin westigation, in my o	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) a date and p	nd manner as s lace, and due t	stated. to the cause(s)
	o the ithin o the omple	Me	29b. Signature and Http/) certifier	1		29c. Licens	e number		29d. Date	signed (Month,	Day, Year)
	⊢ ≯ ⊢ ŏ		\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	1		DIGL	195		J	une 10,	2004
	24		30. Name and address of person who co	moleted cause of death (Its	em 23a) (Type		ביי				
			Joel L. Goozh, M.			Rd., Rock	ville. M	aryland	208	52	
· #	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sig		1					
1	Regist	rar	JUN II ZIN	14 Janes	- 2	April.	. /				

		For State Registrar	State of	Marylan		artment			and M	_	giene Reg. Non		4	
Physicia		Decedent's Name (First, Middle, La	Shirley	-		ТНКОР		-		2. Date of Da Month June 3	ath C.	UU	ear	12:00 P
/Medic Examin		4a. Facility Name (If not institution, gir Sunrise Assisted		oer)		-		Location o	of Death	June 5		County of Mont		
Funeral Director		050-14-0668	Sex 7. 1 □ M 2 ☆ F	. Age (In yrs.	ast birthday) 3 Yrs.	If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Bin May 10	th Years	21 N	Birthpla Counti	
faryland show	or	Usual Residence of Decedent 10a. State 10b. County Maryland Montgon	ne r v	10c. Cit	y, Town or Lo	cation 01ney							10	d. Inside City Limits 1 ☐ Yes 2 ☑ No
with the Na or 28a-1	Funeral Directo	10e. Street and Number 18504 Heritage Hi		e		10f. Zip		32				zen of Wha		ry?
ING 21215-UU36 be filed within 72 hours after death with the Maryland lat Hygiene. d other than "natural", or itams 23a or 28a-f show event, the Medical Examinar must be notified at	by Funera	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Deced Armed Forc 1 Tes 2 If Yes, Give Year or Date	es? ∏No		Vas Decedi f Yes, spec		spanic Origin, Mexican	gin? (Spe i, Puerto l	city Yes or No Rican, etc.)		4. Race - Black, V	America White, e	tc.
d 21215-0036 filed within 72 hours af Hygiene. Hygiene "natural", or ther than "natural", or ont, the Medical Exern	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4	lor 5+)		lent's Usua kind of wor DO NOT us hier	l Occupa k done d e retired,	ition luring most)	t of workii	ng		nd of Busin		•
Maryland 2 d 2 should be filed th and Mentai Hygi ty Is marked other traumatic event,	To Be Co	17. Father's Name (First, Middle, Las	David Co	hen	<u> </u>			18. Mothe		(First, Middle,				
, Mary and 2 shot calth and N 27 Is ma ar trauma		19a. Informant's Name/Relationship Lisa Feldman, Dau			18504	Heri	tage	Hi11		., Olne			ate, <i>Zip C</i>	•
Baltimore, Maryland permit. Pages 1 and 2 should be fil Department of Health and Mental H Important: If item 27 is marked out any injury or other traumatic even		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 1 □ Donation 5 □ Other (Speci		ale	lace of Dispo emetery, cren ath Is					ate 6/04		eation - Cit		
Ball permit. Depart Import any inj		21. Signature of Fundam Service Lice 23a. Part1. Enter the disease, or conshock, or heart failure. List only		5	To	Name and rchin 4 Car	c 127	Hohre	our En	neral I Washi	Home	ı. DC		.012
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Hecords, P.O. Box 687 The law requires that the death certificate tite has been signed by the attending phys age 2 should be detached for use as the	Physiclan/Medlc	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		h 2 ☐ Feta nt at time of d	death 3	Ectopic pre					23	3d. Date of Month		/ Day Year
ecords, P. law requires that as been signed by 2 should be deta	þ	Part II. Other significant conditions	contributing to dea	th but not resi	ulting in the ur	nderlying ca	use give	n in Part I.						cause of death?
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r VITAI H ysician: The is certificate h director, page	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 □ Inc	nationt 2	ER/Outpatien	3 🗆 🗅	Othe			(Check only o		E-Othor (Cassiful.	Assisted
ng Ph fter th neral	ation: To	27. Manner of Death 1 □Natural 5 □ Pending 2 □ Accident investigation	28a. Date of (Month,		28b. Time of Injury		Bc. Injury Work	at ? 'es 2 □ N	2	8d. Describe h				Assisted Living
i gift o	Certification;	3 ☐ Suicide 6 ☐ Could not to determined	building	, etc. (Specif)					4	8f. Location (S City or Tow	vn, State)			
To the Hospital Within 24 hours a To the Funeral I completely filled	edical	29a. Certifier 1 Certifying P (Check only one) 2 Medicel Exe	hysicien: To the b miner: On the bas and manne	is of examinat	wledge, death tion and/or inv	occurred a restigation,	it the time in my op	e, date and inion, deat	d place, a th occurre	nd due to the o	cause(s) a date and p	ind manne place, and	r as stat due to th	ed. he cause(s)
To the within 2 To the complet	Me	29b. Signature and title of certifies	0_				License		, , ,	2		signed (M		
6		30. Name and address of person who	completed cause	of death (Item	23a) (Type, I			174			June	4, 2	2004	
		Swaroop G. Rao	M.D., 50	W. Edi	nonsto		#5	04 Ro	ckvi	11e, M	20	852		
Sta Registr		31. Date filed (Month, Day, Year)	004 32. Reg	gistrar's Signa	B	Spo	uks	/						

			For State	State of Marylar				ind Men		0001	20011
			Registrar		Cei	lilicate	of Death	2.5	Reg Date of Death	I. No./	3. Time of Death
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Margaret Hibble	Russell				l N	me 9.	Day Year 2004	1:25 am
	Examin		4a. Fecility Name (If not institution, give str	eet and number)		4b. City, T	own, or Location of		,	4c. County of Deet	h
			Wilson Healthcare	at Asbury V	illage	Gait	thersburg			Montgom	ery
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		If Under	Year If Under 2 Days Hours		Date of Birth Month, Day,	9. Birt	hplace (Stete or Foreign ountry)
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p	,		Usual Residence of Decedent 10a. State 10b. County	100 0	ity, Town or Lo	cation					10d. Inside City Limits
aryla	ehow stat	-	Maryland Montgomer		ithers						1 ☐ Yes 2 ☐ No
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vith th	or 2	Dir	10e. Street and Number			10f. Zip			109	g. Citizen of What Co	ountry ?
ath v	23	ra	407 Russell Avenu	e, Apt. 215 . Was Decedent Ever in U	1.6		0877 ent of Hispanic Orig	in? (Canada)	Vac or No.	USA 14. Race - Ame	nican Indian
er de	E a	Funeral	11. Marital Status 12 Married 12 Married	Armed Forces?	13.	If Yes, speci	ify Cuban, Mexican,	, Puerto Ricai	n, etc.)	Black, White	
rs aft	0,	by F	3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2	No Specify:			SpecifWhit	e
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	a de	Completed	(Specify only highest grade of		(Give	kind of work DO NOT us	k done during most e retired)	of working			
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D ===	othe ent,	Be C	17. Father's Name (First, Middle, Last)					r's Name (Fir	st, Middle, Me	eiden Sumame)	
d be	ked ked	To B	Walter L. Hibble	<u>)</u>			Fran	nces So	chombe	ct	
shou	M Du	-	19a. Informant's Name/Relationship (Type	o, Print)	19b. Maili	ng Address				City or Town, State, 2	Zip Code)
M 2	27 is		W. Christopher Nei	.11/ Grandso	n 7203	3 Stov	er Drive,	, Alexa	andria	, Virginia	22306
s - s	item othe		20a. Method of Disposition	1	Place of Dispo cemetery, crei	sition (Nam	e of her place)	June	10	Oc. Location - City or	Town, State
730 Page	CE E B		1 Burial 2 Cremation 3 Rei	noval from State	letropo	Litan		200		lexandria	, Virginia
Saltimor	Department of Health and Mental Hygiene. Important: or fleme 23e or 28e-f ehow Important: If item 27 is marked other than "natural", or fleme 23e or 28e-f ehow any injury or other traumatic event, Ita Medical Examinet must be invitible 1 at once.		21. Signature of Funeral Service Ligensee		Crem	a tory	Address of Facility	y			
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	100		23a. Part1. Enter the disease, or complied	ations that caused the dea	ith. Do t en	ter the mode	of dying, such as	cardiac or res	piratory arres	iver Spri	Interval Between
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ecord	s be 2 sho	Completed							24a. Was an autopsy	24b. Were au	utopsy findings available completion of cause of
The law	page 2	Eo							performe	ed death?	2 No
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Vsici	this certific	To B	examiner? 1 ☐ Yes 2 ☐ No	spital: 1 Inpatient 2	☐ ER/Outpatie	nt 3 DO	A Other: 4 Nu	rsing Home	5 Residen	ce 6 Other (Spe	cify)
ם ר אים פא	h. After th funeral		27. Manny of Death	28a. Date of Injury (Month, Day Yeer)	28b. Time o	of 28	8c. Injury at Work?	28d.	Describe how	v injury occurred	
Ö	death. ctor: Af y the fur	atic	1 Natural 5 Pending 2 Accident Investigation			М	1 Yes 2 1	No			
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DIVISION OF VITA	within 24 hours after deatl To the Funeral Director: completely filled in by the	ledi	one)	and manner stated.							
F	5 × 0 0	Σ	29b. Signature and file of cartifier	,		290	. License number	10	29	d. Date signed (Mont	200A
1	6		1/1/	ww		1	1.0012	18		JUIL 1	2007
			30. Name and address of person who con		эт 23а) (Туре,	Print)	uccall A	91/	624	l-n his	mal
				32. Begistrar's Sign	nature =	11110	U>>011 /	٧٥	O all	hersburg	1110,
	St: Regist	ate	31. Date filed (Month, Day, Year)	32. Hadyistrar's Sign	5	100	ulas				

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No./ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** PETER H. RUVOLO JUNE 3, 2004 9:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner POTOMAC 9108 FALLS CHAPEL WAY MONTGOMERY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F Yrs. 118-24-4979 NEW YORK Director JAN. Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28a-f ehov sust by rectified at 1 X Yes 2 No MARYLAND | MONTGOMERY POTOMAC Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9108 FALLS CHAPEL WAY 20854 U.S.A. filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status traumatic event, the Medical Examinary 1 ☐ Never Married 2 X Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: WHITE δ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Means once. Elementary/Secondary (0-12) College (1-4or 5+) 5+ ATTORNEY FEDERAL GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဥ CATHERINE PETER HERBERT RUVOLO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SUSAN J. RUBIN/WIFE 9108 FALLS CHAPEL WAY, POTOMAC, MARYLAND 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ^ 4 □ Donation 5 □ Other (Specify) COMFORT CREMATORY 06/07/2004 ALEXANDRIA, VIRGINIA eDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852 21. Signature of Funeral Service L mald 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** RENAL FAILURE MONTHS 6 /Medical Due to (or as a consequence of) **Examiner** MYLODYSPHASIA OVER 3 YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due (o (or as a consequence or) Examiner The law requires that the death certificate be executed burial-transit 1999 PROSTATE CANCER and Due to (or as a consequence of) P.O. Box 68760 attending physician Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? j Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, ed bluods 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 X No or Attending Physician: 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛱 No this funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After 1 Natural 2 ☐ Accident 5 Pending investigation after death.

I Director: Af id in by the fur 1 Yes 2 🗌 No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospital Within 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only onel and manner stated 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) CLAA JUNE 3, 2004 use of death (Item 23a) (Type, Print) 30. Name and address of person who completed of FRANKE WESTPHAL, 1202 SEVEN LOCKS #202, ROCKVILLE, MD 20853

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUN 0 8 2004

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene

			Certificate of Death	,	Reg. No. ()	11 22216
	Dhusinia		1. Decedent's Name (First, Middle, Last)	2. Date of De		Year 3. Time of Peath
	Physicia /Medica		Clement William Rowan	June		2004 0940 AM
	Examine	er	4a Facility Name (If not institution, give street end number) 4b. City, Town, or	Location of Deat	h 4c. County	of Deeth
			SunBridge Care Center Elkton		Cec	il
	Funeral		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 1 Var If Under 1 Year If Under 24 Hrs 1 M 2 F 7 F 1 Yrs.		rth ay, Year)	Birthplace (State or Foreign Country)
	Director		183-22-8152 · 75 Yrs. Usuel Residence of Decedent	July 14	, 1928	Pennsylvania
	tend wo		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Mary Fig.	힏	Delaware New Castle Wilmington			1 ☐ Yes 2 🎇 No
	1 the	Director	10e. Street end Number 10f. Zip Code		10g. Citizen of	What Country?
	With Man	₫	7 Newark Union Public Road 19803			
	deeth	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (5	Specify Yes or No		d States e - American Indian,
9	after or the contract of the c	Ē	Armed Forces? If Yes, specify Cuban, Mexican, Puer 1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☑ No	to Rican, etc.)		ck, White, etc.
93	er, c	<u>۾</u>	3 ☐ Widowed 4 ☐ Divorced If Yes, Give 1 ☐ Yes 2 ☒ No Specify: Year or Dates:		Specify	White
5-0	within 72 hours after deeth with the Maryland ans. than "naturel", or frame 23s or 28e-f show the Medical Evarainer must be notified at	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of wo	dina	16b. Kind of B	usiness/Industry
2	within ena.	힏	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)	iking	Auto	mobile
7	be filed within tel Hygiena. d other than event, tre H	ပ္ပံ	4 Electrical Engineer		Manu	facturing
P	d of H	Be		me (First, Middle	, Maiden Surnan	ne)
yla	should be f and Mantel H marked of numetic eve	ို		eth Jack	son	
Jar			19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or R			
ď.	1 and 2 Health em 27 i		Maureen Rowan/Daughter 2423 South Street, Ph. 20a. Method of Disposition 20b. Place of Disposition (Name of			
0	ges Toff		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State C+ ☐ C+	Date	Chesar	City or Town, State Deake City,
ţ	tmen tant:		4 □ Donation 5 □ Other (Specify) St. Rose of Lima Cemetery	6/21/04	Marvla	ind
Baltimore, Maryland 21215-0036	permit. Pages 1 an Depertment of Heal Important: if item 2 eny injury or other pnce.	ŀ	21. Signature of Funeral Service Licensea 22. Name and Address of Facility Hicks Home for Fun	erals, F	P.A.	
			103 W. Stockton St	reet, El	kton, M	D 21921
			23a. Part1. Enter the disease, or complications that a sed the death. Do not enter the mode of dying, such as cardial shock, or heart failure. List only one cause of each line.	c or respiratory a	rrest,	Approximate Interval Between
	Physician					Onset and Death
	/Medical Examiner		Immediate Cause (Final disease or condition			months
		_	resulting in death) Due to (or as a consequence of):			
	p # #	Examiner	b			1
	death certificate be executed eattending physicien end ad for use es the buriel-transit	xau	Sequentially list conditions, if any, leading to immediate			
68760,	be ed lclen burie	<u>8</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.			65
587	icate phys s the	Medical	that initiated events resulting in death) Last Due to (or as a consequence of):			
×	leath certific attending pl	Š	d			
Bo	atter for u	Physician				
P.O.	ras that tha de signed by the a libe detached i	2	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		/	ntribute to the cause of death?
	± 0 0 ≥	2		10	Yes 2⊠ No	3 Probably 4 Unknown
2 Sp.	requiras			24a, Was	an autopsy	24b. Were autopsy findings
8	been si should	<u>e</u>			med?	available prior to completion of cause
Vital Records,	The law ata has b	Completed				of death?
ta	ician: The certificata rector, per		25. Was case referred to medical 26 Place of Dec	101		1 ☐ Yes 2 ☐ No
>		n	examiner?	ath (Check only o		
Division of	Phys arthis erel d		27. Menper of Death 28a. Date of Injury 28b. Time of 28c. Injury at	lome 5 ☐ Resid	now injury occurr	
o	Attending in death. Sector: After by the fune.		1 ☑Natural 5 ☐ Pending (Month, Deý Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No			
<u>/s</u>	or Attendation of the properties of the properti		3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office			er or Rural Route Number,
á	tal or Attending P rs after death. al Director: After t led in by the funer	9	4 ☐ Homicide building, etc. (Specify)	City or Tou	vn, State)	
	Hospital 24 hours Funeral staly filled	100	29a. Certifier (Check only Check on Check	, and due to the	ause(s) and ma	nner es steted.
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completaly filled in by the funeral Madical Cartification.	ğ	(Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occur and manner stated.	rred at the time,	date and place, a	and due to the cause(s)
	With To t	Σ	29b. Signature and title of certifier 29c. License number		29d. Date signed	(Month, Day, Year)
}	-3		DUOSGLAR		JUNE	17,2009
	14		30. Name end address of person who completed cause of death (Item 23a) (Type, Print)	1) 0>	. \	
	10		STANIMULE 2-01 EVA ANNASISSI SOIL CHI DISAS 9 POTULOS	N , VEU	IMARE 1	1806
	State	9	31. Date filed (Month, Day, Year) 32. Registrar's Signature			
	Registrar	r	JUN 2 3 2004 Mayer & Spartes"			
DHM	IH 16 Rev 6/95		ORIGINAL			

		1 - For State Registrar	State of	Marylar	•	artmen rtificate			ınd M	lental H	lygiei Reg.	20	n L	20017
Physici /Medic	al	Decedent's Name (First, Middle, L Caellin Name (Mast institution)	Carri		uline		inaı			2. Date of Month June	17		Yeer 004	3. Time of Death 5:40 P M
Examin	er	4a. Fecility Name (If not institution, g Angelic Arms 5. Social Security Number 6.			last birthday)		eyto	Location of WIT If Under 2		8 Date of I		Carr		County
Director		212-24-6044 Usual Residence of Decedent	1□M 2(X)F		95 Yrs.	Months	Days	Hours	Min.	8. Date of E (Month, July	Dey, Ye 30 1	908		place (State or Foreign ntry) Cyland
5-0036 72 hours effer deeth with the Maryland nature!, or Items 23e or 28e-f ehow allcal Examinar must be notified at	by Funeral Director	10a. State 10b. County Maryland Carrol 10e. Street and Number 2467 Feeser Road 11. Marital Status 1 Never Married 2 Married 3 W Widowed 4 Divorced	1 County 12. Was Decede Armed Force 1	Ta ent Ever in U es? MNo	'	n 10f. Zip 2	1787 ent of His rfy Cubar		in? (Spe Puerto l	cify Yes or l	Uni	ted :	What Cou State	es can Indian, etc.
	Be Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12) 5 17. Father's Name (First, Middle, Las William G. Sowe	Education rade completed) College (1-4:		life. I	dent's Usua kind of wor DO NOT us ine o	k done di e retired) pera	tor 18. Mother	's Name	ng (First, Midd Grace 1	ga le, Maid	Kind of B	usiness/In	dustry
_ 5 % N F	2	19a. Informant's Name/Relationship Mildred P. Wado 20a. Method of Disposition	(Type, Print)			5 Sel	ls M		or Rura oad	Route Num	ber, City	v or Town, Wn , N		and 21787
Baltimore, permit. Peges 1 e Department of Hee mportent: If Item ny injury or othe mee.		1 ☑ Burial 2 ☐ Cremation 3 '4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Lice	ify)	. 0	emetery, cren nity L	natory or of uther	an C	emete:	ry ^J Ski	une 21 2004 les Fi	Ta Iner	ņeyto al Ho	own,	Maryland
Daning permit pe	V 13	23a. Pert1. Enter the disease, or cor shock, or heart failure. List only	mplications that cause on each	sed the deat	1	36 Ea	st B	altim	ore	Street	T	aneyt	cown,	MD 21787 Approximate Interval Between
/Medical Examiner physicien and the burial-transit	Exa	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last	b	as a consequas a consequas a consequas a consequas a consequas a consequas acconsequation of the consequant consequation of the consequence of the	uence of): uence of):	nha								Onset and Death
O. Box 6 he death certifile rithe attending p	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⊡ No 9 □ Unknown	23c. If yes, outcor 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknowr	2 ☐ Fetal	I death 3	Ectopic pre						23d. Dat	te of delive	ory Day Year
cords, P.	۵	Part II. Other significant conditions	contributing to death	but not resi	ulting in the un	derlying ca	use giver	n in Part I.					ribute to th	ne cause of death? ably 4 (30nknown
	Completed								_		opsy ormed?		teath?	psy findings available inpletion of cause of
of Vital Physicien: 1 This certifice	2	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpa		ER/Outpatient		Other	4 ☐ Nurs	ing Hom	(Check only le 5 Res 8d. Describe	idence		er (Specify	Assisted
Division of To the Hospitel or Attending Phywithin 24 hours effer deeth. To the Funeral Director: Affer thi completely filled in by the funeral of the funeral or the funer	Certification;	1 Matural 5 Pending 2 Accident investigatic 3 Suicide 6 Could not l 4 Homicide determined	on 28e. Place of	Day Year)	Injury ome, farm, stre	М		as 2 □ No	>		(Street a	und Numbe		Route Number,
DIVISION To the Hospitel or Attentivition 24 hours effer deel To the Funeral Director: completely filled in by the	edical Ce	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the be miner: On the basis and manner	of examinal	wledge, death tion and/or inv	occurred a estigation, i	t the time in my opii	, date and nion, death	place, ai	nd due to the	cause(, date ar	s) and ma nd place, a	nner as stand due to	ated. the cause(s)
To th within To th compl		29b. Signature and title of certifier	MO			29c.	License	20 35			29d. D	ate signed	I (Month, L	Day, Year) 18 2004
6		30. Name and address of person who	completed cause o	death (Item	/5	Print) We	,	Wen	rmi	neta		MO	21	157
	State Registrar World Month, Day, Year) 32. Registrar, Signature State Stat													

Kevin Wesley Stearman 04-038 RPD

unpend item#23a,27,28a-f,PFR ME,Q832,6/30/04eg

038	320		Please	• •			th and Mental Hy	_	
			For State Registrar	State of Ma		rtificate of Dea	_	Reg: No 1	20018
	Physici		1. Decedent's Name (First, Middle, Las Kevin Wesley Steam	•			2. Date of De Month June	Bath Day Year 8, 2004	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or Loca		4c. County of Deatl	
	_ Aujiiii		22300 Flintridge I			Brookevil		Montgomer	
	Funeral Director		223-84-0638	ex 7. Age ⊠M 2□F	(In yrs. last birthday) 47 Yrs.		ours Min. 8. Date of Bi (Month, Di August 2		pplace (State or Foreign untry) Lrginia
)	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation			10d. Inside City Limits
	the Marylan 28a-f show	Funeral Director	Maryland Montgome	ery	Brookevi1	1e		10g. Citizen of What Co	1 ☐ Yes 2√2 No
	with t	Dir	22300 Flintridge I	Orive		20853		United Stat	
	death	nera	11. Marital Status	12. Was Decedent E	ver in U.S. 13.		lic Origin? (Specify Yes or No exican, Puerto Rican, etc.)		ncan Indian,
920	72 hours after death with the Maryland naturel', or tems 23a or 28a-1 show Issal Examination to indiffed at	by	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	0	_	ecify:	Specify:	ite
21215-0036	permit. Pages I and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Mental Hyglene. Importent: If item 27 is marked other then "naturel", or Items 23a or 28a-1 show any injury or other traumatic event, the Markeal Examble for must be motified at once.	Completed	15, Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ducation ide completed) College (1-4or 5-	(Give	dent's Usual Occupation kind of work done during DO NOT use retired)	most of working	16b. Kind of Business/	ndustry
212	filed with Hygiene other the	Com	-	4		dent/ CEO		Recycling	
pu	be file	Be	17. Father's Name (First, Middle, Last)				Mother's Name (First, Middle		
Maryland	should nd Men marke umatic	2	William Robert Ste		19h Maili		aryelee Ubert Jumber or Rural Route Numb		in Code)
Ma	id 2 sl ith an 27 Is r traur	ľ i	Brian J. Stearman,				s Drive, Vien	•	
re,	is 1 and of Health item 27 other to		20a. Method of Disposition		20b. Place of Dispo	esition (Name of matory or other place)	Date	20c. Location - City or	Fown, State
imo	Pages nent of H ant: If its		1 ⊠ Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specify	v) \	Memorial		June 14, 2004		
Baltimore,	permit. Departr Importe any inj		21. Signature of Funeral S Whe Lice	MOC	0689 R	ockville, I	FacilityRobert A.nc. 300 West Maryland 20	Montgomery A	neral Home/ Avenue,
	Physician /Medical		23a. Part I Phier the disease, or com shock or hear failure. List only Immediate Cause (Final disease or condition resulting in death)	Cocaine ar	the death. Do not ente. ad Hydrocodor	er the mode of dying, suce Intoxication	ch as cardiac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Examiner			Due to (or as a	consequence of):	7å.		10	
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):	.6.			
	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as a	consequence of):				
760,	e be ex rsician e burial	aiE		200 10 (01 43 0	consequence or,				
687	ificate g phys as the	edic		d					
Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burral-transit	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at 9 ☐ Unknown	2 ☐ Fetal death 3 [Ectopic pregnancy Other (specify)		23d. Date of deli Month	very Day Year
P.O.	that the	y Ph	Part II. Other significant conditions of	ontributing to death bu	it not resulting in the u	nderlying cause given in	Part I. 23e. Did	tobacco use contribute to	the cause of death?
rds	quires an sigr uld be	q pa					1 🗆	Yes 2 ☐ No 3 ☐ Pro	bably 4 Ninknown
of Vital Records,	he law re e has bee age 2 sho	omplet						ormed? death?	topsy findings available ompletion of cause of
tal		ø	25. Was case referred to medical			26.	Place of Death (Check only		2 No
Ž	Physicien: r this certific ral director,	To B	examiner? 1 XYes 2 No	Hospital: 1 ☐ Inpatier	nt 2 ER/Outpatie	nt 3 DOA Other 4	□ Nursing Home 5 □ Res	idence 6 Other (Spec	ify) At Scene
o u	ing Pl		27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury fourthorth, Day	Year) Curid ury	Work?	_	how injury occurred	
Division	death. ctor: A y the fu	icat	2 Accident investigation 3 Suicide 6 X Could not b	0/0/04	7:20 j		28f. Location (Street and Number or Ru	ral Route Number.
Di≤	after Direct	Certification:	4 Homicide determined	building, etc	ry - At home, farm, st. . (Specify)	eet, lactory, onice	22300 FLi	wn, State) ntridge Dr.,Br	ookeville,MD
	To the Hospital or Attending Physwithin 24 hours after death. To the Funerel Director: After this completely filled in by the funeral directors.	Medical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	nysician: To the best of miner: On the basis of and manner sta	examination and/or in	h occurred at the time, da vestigation, in my opinior	ate and place, and due to the	cause(s) and manner as date and place, and due	stated. to the cause(s)
	ro the vithin ro the comple	Me	29b. Signature and title of certifier			29c. License nun	nber	29d. Date signed (Month	, Day, Year)
	- >= 0		> Unete_	r		O.C.M.E		June 9, 200)4
			30. Name and address of person who	completed cause of de			eet, Baltimor	e, Maryland	21201
**	Sta Regist		31. Date filed (Month, Day, Year) JUN 1 5 20	32. Registra	r's Signature	Spark			

DHMH 17 Rev 1/2001

			1 - For State Registrar	State o	f Marylan		artment of H rtificate of L			-	giene	004	200	19
	Physici		Decedent's Name (First, Middle Joy	, Last) Delila	h		Slick			2. Date of Dea Month June	Day	Year 2004	3. Time of 4:00	Death P M
	/Medio Examin		4a. Facility Name (If not institution	, give street and nur			4b. City, Town, or	Location of	of Death	ounc		ounty of Death		
			11307 Marbern F				Hagersto				Wa	shingt		
	Funeral Director		5. Social Security Number 214-34-0634	6. Sex 1 ☐ M 2 💢 F	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min,	8. Date of Birt (Month, Day	/, Year)		place (State of intry)	r Foreign
			Usuel Residence of Decedent		68				<u> </u>	Jan. 9	, 193	b Mar	yland	
	inylan ihow	_	10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside Cit	•
	8a-fs	Director		ngton	Hag	ersto							1 X Yes	2 🗆 No
	filed within 72 hours after death with the Maryland Hygiene. Hygiene Inatural; or Items 23a or 28a-f show ther then "natural; or Items 23a or 28a-f show ant, It & Medical Examine must be notified at	ă	10e. Street and Number 11307 Marbern I	o a d			10f. Zip Code					n of What Cou	intry?	
	ns 23	by Funeral	11. Marital Status		dent Ever in U.	S. 13.1	21740	soanic Ori	igin? (Spec	cify Yes or No-	U.S.	A . Race - Ameri	can Indian	
ယ	after o	Fun	1 Never Married 2 Marr	Armed Fo ed 1 ☐ Yes	rces? 2[X]No		Was Decedent of Hi f Yes, specify Cuba			Rican, etc.)		Black, White		
000	ours a		3	If Yes, Giv Year or D	e ates:		1 ☐ Yes 2 💢 No	Specify:			S	pecify: Whi	te	
5-("natu	Completed	15. Decedent (Specify only highes			16a. Deced (Give	lent's Usual Occupa kind of work done o DO NOT use retired,	tion <i>(uring</i> mosi	t of workin	g	16b. Kind	of Business/Ir	ndustry	
12	withir ene. then	duc	Elementary/Secondary (0-12)	College (1	-4or 5+)		maker	,			Dom	estic		
ק	e filled Hygi other	Be C	17. Father's Name (First, Middle,	Last)				18. Mothe	er's Name	(First, Middle,				
/lar	should be nd Mental marked o	To B	Paul Rohrer, Sr	•				Vio.	la Mo	Allist	er			
Maryland 21215-0036	C1 42 28 18		19a. Informant's Name/Relations	, , , , ,		19b. Mailir	g Address (Street a	nd Numbe	er or Rural	Route Numbe	r, City or T	own, State, Zi	Code)	1
e,	1 and Health Brm 27 ther tr		Betty Slick/Da 20a. Method of Disposition	ughter	20h PI	11307	Marbern	Road		erstow				
nor	ages int of litter it it	-	1 ☐ Burial 2 ☐ Cremation		Jiaio		sition (Name of natory or other place					tion · City or T		
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 eny injury or other		* 4 □ Donation 5 □ Other (S _i 21. Signature of Funeral Service		IKES		n Cemeter Name and Addres		6/8/2		ager	stown,	MD	
ă	permi Depa Impo eny ir		5. Mark S	in		16	01 Pennsy	lvan:	ia Av	e. Hag	erst	erai Cr own. Mi	nape⊥) 21742	
	/Medical Examiner	Examiner	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Unusying Cause (Disease or injury that initiated events	aDue to (r as a consequ		1 Rp. Ho	315					Interval Betwonset and D	
	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/Medical Ex	IF FEMALE: 23b. Was decedent promant in the past 12 morths? 1 Yes 2 No 9 Unknown	d	or as a consequicome of pregnar inth 2 Fetel ant at time of de	ncy death 3	Ectopic pregnancy Other (specify)				230	. Date of delive	-	9ar
S, P	ires that the signed by the detaction	þ	Part II. Other signific int condition	contributing to de	ath but not resu	Iting in the ur	derlying cause give	n in Part I.				<i>e</i>	ne cause of de	
Ö	w requir been si should	eted	1 1487071	CH ONLY					-	1 🗆 Yı		7		
Division of Vital Record	ıysicien: The law iis certificate has l director, page 2 (Completed								24a. Was a autops perform	y 🖊	prior to co death?	psy findings av mpletion of cau 2 No	vailable use of
₹	Physicien: r this certifica ral director, I	o Be	25. Was case referred to medical examiner? 1 ☐ Yes, 2 ☐ No	Hospital:	npatient 2 🗆 E	EB/Out action	Otho	_		Check only on		1011 (0 11		
٥	g Physics this seral di	n; To	27. Manny of Death	28a. Date of		28b. Time of Injury	28c. Injury Work			e 5 Reside			Y)	
<u>io</u>	Attending r death. ector: After by the fune	atlo	1 atural 5 Pending	ation	i, Day 1661)	injury		es 2 🗆 N	No					
<u>Š</u>	5 # in ⊆	Certification;	3 Suicide 6 Could r 4 Homicide determi	nod Zee, Place	of Injury - At hor ng, etc. (Specify,	me, farm, stre)	et, factory, office		28	If. Location (St City or Town	reet and N n, State)	umber or Rura	d Route Numbe	er,
	To the Hospitel within 24 hours a To the Funeral i completely filled	edical	29a. Certifier 1 Certifyin (Check only 2 Medical I	g Physician: To the Examiner: On the ba and mann	isis of examinati	vledge, death ion and/or inv	occurred at the time estigation, in my opi	e, date and inion, deat	d place, an	d due to the car at the time, d	ause(s) and ate and pla	d manner as si ice, and due to	ated. the cause(s)	
	Toti comp	ž	29b. Signature and title of certifier **DUSK** 7	r Ac	10/7	40	29c. License	number	557	23 2	9d. Date si	gned (Month,	Day, Year) 2らり	
<u>h</u>	H,		30. Name and address of person	no completed cause	death (Item	23a) (Type, I	Print)	10 A	10,	ticac	121	1001	LODI	7
	Sta Registra	_	31. Date filed (Month, Pay Yerr)	3 2004 32. R	gistrar's Signati	ure	1	H.	14	ELITO	4/1	171	217	10

			riease				Ensure All Co		9	
			For State	State of IV		artment of He rtificate of D	ealth and Menta		0001	20020
			Registrar 1. Decedent's Name (First, Middle, La	st)	<u> </u>	runcate or L		Reg e of Death	1. NG. U U 4	3. Time of Death
	Physici		Anna Catherine S	•	ECV.		Mo Ju	nth	Day Year 3 Zoo4	
	/Medi Examir		4a. Facility Name (If not institution, giv			4b. City, Town, or		116 .	4c. County of Dea	
			Washington Count	y Hospital	L	Hagers	stown		Washing	ton
	Funeral		Social Security Number 6. S		ge (In yrs. last birthday)			of Birth oth, Day, Y		thplace (State or Foreign ountry)
	Director		213-12-/369	□M 2 X F	83 Yrs.			22 1		yland
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Marylan -f ahow lied at	to	Maryland Washin	rton	Ua	coratorm				1 ∑Yes 2 ☐ No
	r 28e	Director	10e. Street and Number	gcon	IIa	gerstown 10f. Zip Code		10g	3. Citizen of What Co	ountry?
	be filed within 72 hours after death with the Maryland hal Hyglene. dother than "natural", or Items 23a or 28e-f ahow event, the Medical Examinar must be notified at	a D	1018 Brinker Dri	ve #102		217	740		U.S.A.	
	r dea	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S. 13.	Was Decedent of His	spanic Origin? (Specify Ye n, Mexican, Puerto Rican, e	s or No-	14. Race - Ame Black, Whit	
36	s afte , or li	by Fu	1 ☐ Never Married 2 💥 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔯	No	1 ☐ Yes 2 🎇 No		•	Specify:	
21215-0036	hour	ed b	15. Decedent's E	Year or Dates:	16a Dece	dent's Usual Occupat	tion	10	b. Kind of Business	White
15	nin 72 n "ne	plet	(Specify only highest gra Elementary/Secondary (0-12)	ide completed)	(Give	kind of work done du DO NOT use retired)	uring most of working	10	D. KING OF BUSINESS	moustry
212	d with giene ar tha	Completed	10	College (1-4or		rdresser			Hair Salo	n
	be filed ital Hygie of other event, II	Be	17. Father's Name (First, Middle, Last,				18. Mother's Name (First,			
yla	should be filed within and Mental Hygiene. Is marked other than aumatic event, the Manatic event, the Manati	2	Max M. Smith				Annie C. Ba	arnes		
Maryland	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship (^{Турө, Print)} Hust	and 19b. Mailir	ng Address (Street ar	nd Number or Rural Route	Number, C	City or Town, State, .	Zip Code)
	s 1 and 2 of Health item 27 other tr		Albert R. Schlott 20a. Method of Disposition	terbeck, J		Brinker I	Drive #102 Ha		town, Md.	
٥			1 X Burial 2 ☐ Cremation 3 ☐		'	sition (Name of matory or other place	ı	20	c. Location - City or	rown, State
Baltimore,	permit. Page Depertment of Important: If any injury or once.		'4 ☐ Donation 5 ☐ Other (Specification 21. Signature of Funeral Service Licer			1 Cemetery 2. Na <i>m</i> e and Address				, Maryland
Ba	Dep Imp		1 Ind Pils	A)		15 E. Wils	11111111		neral Home town, Md.	
1			23a. Part1. Enter the disease, or com	plications that cause	d the death. Do not ent					Approximate
W	Pnysician :		shock, or heart failure. List only Immediate Cause (Final disease or condition		STIVE	HEAD-	FAILURE			Interval Between Onset and Death
	/Medical		resulting in death)		a consequence of):	1010	FAILURE PISEASE			112111
8	Examiner		Sequentially list conditions,	D	MRY	APTERY STENOS	PISEASE	er-		YEARS
	ed sit	lner	ri any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Λ	a consequence of):	C	īc			Yrues
6	be executed ician and burial-transit	Examin	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):	SIDMS	• •			(KA)
760,	ficate be execute physician and ts the burial-trans	calE	(d						
99	tificat ig phy as thi			· ·						
Вох	eath certific attending pl for use as f	N/us	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		Ectopic pregnancy			23d. Date of del	ivery
	e deal	Physician/Med	in the past 12 months?			Other (specify)	-		Month	Day Year
P.0	that the de ed by the detached	Phy	9 Unknown			4-1-1		Didasts		
ds,	es gu	l by	Part II. Other significant conditions of		1GOMEY		SEASE 236	. Did tobac	1	the cause of death?
Ö	w requir been si should	etec	AMEMIA	1/10-						
Vital Records,	The lav ate has page 2	ompleted	TIMETITY				248	 Was an autopsy performed 	prior to d	topsy findings available completion of cause of
ta		e Co	25. Was case referred to medical					performed Yes 2	No 1 ☐ Yes	2□ No
Ξ	ys dii	0.8	examiner?	Hospital: Inpati	ent 2 ER/Outpatien	Othor	26. Place of Death Check 4 □ Nursing Home 5 □		e 6 ∏Other (Spec	c(fy)
o u	ng Ph ter th	n: T	27. Manner of Death	28a. Date of nit (Month, Da	ury 28b. Time of	28c. Injury a			injury occurred	ony)
Sio	Attending ir death. ector: After by the fune	atlo	Natural 5 Pending investigation	1	, ,		es 2 🗆 No			
Division	or Att	ertification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of in	jury - At home, farm, str tc. (Specify)	eet, factory, office		ition (Stree or Town, S	t and Number or Ru State)	ral Route Number,
	Hospitel	O	200 Cortifies Distriction Dis	voicion. To the hoot	-6					
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After it completely filled in by the funeral	edical	29a. Certifier (Check only one) Check only 2 Medicel Exem	ysicien: 10 the best niner: On the basis of and manner st	of examination and/or inv	occurred at the time restigation, in my opin	e, date and place, and due nion, death occurred at the	to the caus time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2 To the Complet	Me	29b. Signature and title of certifier			29c. License	number	29d.	Date signed (Month	n, Day, Year)
)	/		VS (Kon	moure, +	W	1	(0764	(06/03/0	04
	45		30. Name and address of person who	completed cause of c	death (Item 23a) (Type,	Print)	60107			,
	7`		B. ROMANIC,	170 12	931 OFF	Mice A	IVE, HAGE	RS 10	own MD	21742
	Sta		31. Date filed (Month, Day Year) 4	2004 32. Resistr	rar's Signature	parke	,			-
	Registr	al			/					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

				State of Mic	•	Certifica			Mental Hyg	leg. No.		
	DI -i-i-		1. Decedent's Name (First, Middle, La	st)	-			•	2. Date of Dea Month		Q _{eat}	5) Time of Death
4	Physici /Medi		Louise Jane Spi						June			7:18am
and the same	Examir		4a Facility Name (If not institution, give				4	b. City, Town, or	Location of Death	4c. County	of Death	
			Williamsport Nurs			16 6 8	1224 242	Willia			ningto	
	Funeral Director		5. Social Security Number 6. S 214-09-4435	ex 7. Ago □M 2፟ATF	e (In yrs. last birt 87	Yrs. Month	der 1 Year s Days	If Under 24 Hr Hours Mir				ce (State or Foreigr
	*		Usual Residence of Decedent						Dec. 0,	1910		ylvania
	ter death with the Merylen Items 23a or 28e-f show Iner must be notified at	'n	10a. Stete 10b. County		10c. City, Towr						10d	Inside City Limits 1 ☐ Yes 2 ☒ No
	the N	Director	Maryland Washing	ton	Hager		Zip Code			Og. Citizen of V	What Country	
	With With	5	13421 Cearfoss	Piko		101. 2	21740)		USA	viiat Country	· :
	death	Funeral	11. Marital Status	12. Was Decedent 8	Ever in U,S.	13. Was Dec			Specify Yes or No- rto Rican, etc.)		e - American	Indian,
020	al', or its Examine	þ	1 ☐ Never Married 2 ☐ Married 3 【X Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2X N If Yes, Give Year or Dates:	lo			sn, Mexican, Pue Specify:	rto Rican, etc.)	Specify Specify	k, White, etc	
21215-0020	filed within 72 hours efter death with the Maryland Hygiene. ther than "natural", or flams 23s or 28s-f show ant, the Madical Examiner must be notified at	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucetion de <i>completed)</i> College (1-4or 5	+)		vork done d use retired	ation during most of wo	orking	16b. Kind of Bu		stry
7	Hygie Hygie Int. II	ပ္	12 17. Father's Name (First, Middle, Last)			Homemak	er	18 Mother's Na	me (First, Middle,	Dome s		
Maryland	id be ental ked o	To Be	John H. Hoffman						Buchanan		-/	
ary	shou and M a mar		19a. Informant's Name/Relationship (7	ype, Print)	19b.	Mailing Addre	ss (Street		lural Route Number			ode)
Σ.	end 2 palth n 27 l		Gary Spickler/Son					s Pike,	Hagersto	wn, Md.	217	40
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if Item 27 is marked other than 'any injury or other traumatic event, the Manace.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □	Removal from State	20b. Place of cemeter	Disposition (A y, cremetory o	ame of rother plac	е)	Date	20c. Location -	City or Town	, State
<u>=</u>	it. Per rtant:	i	4 ☐ Donation 5 ☐ Other (Specify)	Rest I	Haven C		-				Maryland
Ba	Depe Impo any i		21. Signature of Funeral Service Licen						est Haven		-	
			5: Mark Sug		the death. Do n				Avenue, H			
	Physician /Medical		23a. Part1. Enter the diseese, or conshock, or heart failure. List only of	^	• •					est,	In O	pproximate terval Between nset and Death
X.	Examiner		disease or condition resulting in death)	a ACUTE	Due to (or as a c	ARDIAL	nt	TUTTIC	11010		1 11	INVITES
	p : <u>t</u>	Iner	_	, CORON		ART	ERY	NFARCT DISE	ASE		1	
	end end I-trens	хаш	Sequentially list conditions, if any, leading to immediate		Due to (or as e c	onsequence o						
68760,	be es	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c								
289	tificate be executed g physician and as the burial-transit		resulting in death) Last		Due to (or as a co	onsequence of):				1	
ŏ		an/N		d								
E	s deat he att	sick	Part II. Other eignificant conditions co	ntributing to death bu	t not resulting in	the underlying	cause give	en in Part I.	23b. Did to	bacco use con	tribute to th	e cause of death?
P.O. Box	v requires that the death cer been signed by the attendir should be deteched for use	by Physiclan/N							1 □ Y	e 2□ No	3 Probab	iy 4 □ Unknowr
ds,	signe signe d be o	d by							24a. Was a	n autoney	24h Were	autopsy findings
Hecords,	The law requires that the death cer ste hes been signed by the attendir page 2 should be deteched for use	Be Completed							perforr	ned?	availa	ble prior to letion of cause
Ž į	The la	E C							10Ya	is 250,140		es 2□No
Ita	lan: ortifice ctor, p	Be	25. Was case referred to medical examiner?					26. Place of De	ath (Check only on	в)		
5	hysic his ce	2	1 ☐ Yes 2 本No	Hospital: 1 ☐ Inpatier		patient 3 0		4,2 rivuising r	lome 5 ☐ Reside	nce 6 □Othe	r (Specify)	
ב ל	Ilng P	Ë	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Dey		me of jury M	28c. Injury Work	at ? /es 2 □ No	28d. Describe ho	w injury occurr	be	
Division of Vital	Attanding Physician: r death. sctor: After this certifice by the funeral director,	Ificat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Inju	ry - At home, fan			165 2 140	28f. Location (St	reet and Numbe	er or Rural Re	oute Number,
	tal or A is effer al Dirac ed in by	Cert	4 ☐ Homicide	building, etc.	(Specify)				City or Town	, State)		
	To the Hospital or Attanding Physician: The law within 24 hours efter death. To the Funeral Director, After this certificate has completely filled in by the funeral director, page 2	edical Certification:	29a. Certifier 1 Certifying Phy (Check only one) 1 Certifying Phy 2 Medicai Exami	eician: To the best of	examination and	deeth occurre or investigation	d at the tim n, in my op	e, date end place inion, death occu	and due to the ca arred at the time, da	use(s) and mai ite and place, a	nner as state	d. e cause(s)
,	othe othe omple	New Year	29b. Signature and title of certifier	and manner stat	ed.		9c. License			d. Date signed		
	⊢≱Fŏ		1800000				533			Inve i	. 2004	
	1-7	-	30. Name and address of person who c	ompleted cause of de	ath (Item 23e) (1					3,446		
\$	H.J		TED E. HOWE	154 N.	ASTIZA	-	. a) ILLIAM	SPORT,	MD	721	795
	Sta	te	31. Date filed (Month, Hanney) 3 2	004 32. Pagistrai	's Signature	Souls						

			1 - For Státe Registrar	State of Ma	-	partment of ertificate of			giene	20022
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Frederick Elm	f	uffer			2. Date of Dea Month	Day Yes	. 11 0 14
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of Death		4c. County of D	eath
			WASHINGTON COUNTY				GERSTOWN			HINGTON
	Funeral		5. Social Security Number 6. Sex	K 7. Age ŽM 2□F	(In yrs. last birtho	Months Days		8. Date of Birti	y, Year)	Birthplace (State or Foreign Country)
	Director		216-30-2815 Usual Residence of Decedent		14		<u> </u>	MARCH 2	4, 1932	MARYLAND
	how		10a. State 10b. County		10c. City, Town o	Location				10d. Inside City Limits
	8a-fs	Director	MARYLAND WASHIN	GTON			HEWSVILLE			1 ☐ Yes 2 No
	with the	Dire	10e. Street and Number			10f. Zip Code	0.50		10g. Citizen of What	
	ns 23	Funeral	21101 TWIN SPRINGS	DRIVE 12. Was Decedent E	verin U.S.	3. Was Decedent of	21721 Hispanic Origin? (Sp	ecify Yes or No-		S.A. merican Indian.
ယ္	after o		1 ☐ Never Married 2X Married	Armed Forces? 1 ☐ Yes 2 X N	0	3. Was Decedent of If Yes, specify Cut		Rican, etc.)	Black, W	
21215-0036	4 within 72 hours after death with the Maryland liene. r then "naturel", or Items 23a or 28a-f show the Medical Examir at must be notified at	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		Specify:	WHITE
5-("natu	Completed	15. Decedent's Edu (Specify only highest grade		(6	ecedent's Usual Occu live kind of work done e. DO NOT use retire	during most of work	king	16b. Kind of Busine	ss/Industry
12	within then " then "	omo	Elementary/Secondary (0-12)	College (1-4or 5-	+) ""	ROOFF			DOOFING (CONTRACTOR
	Hyg Hyg int,	Be C	17. Father's Name (First, Middle, Last)			KOOLI		e (First, Middle,	Maiden Sumame)	CONTRACTOR
<u>lar</u>		To E	WILLIAM EARL STOUF	FER			EFFIE EL	IZABETH	MONNINGER	3
Maryland	and and sum		19a. Informant's Name/Relationship (Ty		4.	ailing Address (Stree				
	s 1 and 2 f Health item 27 l		SHIRLEY I. STOUFFE	IK/ SPOUSE		BOX 105, sposition (Name of		LE, MAR Date	YLAND 217 20c. Location - City	
no	0 0		1 X Burial 2 ☐ Cremation 3 ☐ R 14 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	cemetery,	crematory or other pla		22/200/		
Baltimore,	permit. Pag Department Important: I any injury o		21. Sign ture of Juneral Servic, Lice se			22. Name and Addr	ess of Facility		d Nationa	WN, MARYLAND
Ä	Depa Impo any ir once.		Jaul 11/4 Cho	w- Paul A	1. Dean	BAST FUNE	RAL HOME		ro, Maryl	
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the cause on each line	the death. Do not e.	enter the mode of dy	ng, such as cardiac	or respiratory are	rest,	Approximate Interval Between
3	Physician		Immediate Cause (Final disease or condition resulting in death)	Coren	any AM	ery Diseas	Te .			Onset and Death
6	/Medical Examiner		resulting in dealth)	Due to (or as a	consequence of):	\ \ \				
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence of):	activo				12-100
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Avori	value	replace	ent			12-years
90,	tte be executed tysician and ne burial-transit		resulting in death) Last	Due to (or as a	consequence of):					()
8760	ate hys	edical		1						
Вох 6	eath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome o					23d. Date of	delivery
œ.	death	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown		3 □Ectopic pregnand 5 □ Other (specify) _	у		Month	Day Year
P.0	at the de d by the a etached	Phys	9 🗆 Unknown							
ls,	ires that signed t	by	Part II. Other significant conditions con	itributing to death but	t not resulting in th	e underlying cause gi	ven in Part I.		bacco use contribute es 2□No 3□	to the cause of death? Probably 4 Junknown
Sor	w requir been si should	letec	Hyperlip donia					24a. Was a		. , ,
Vital Records,	The lav ate has page 2	ompleted						autops	sy prior t med? death	
ital	sicien: Th certificate rrector, pag	e C	25. Was case referred to medical				26. Place of Deat		No 1 Y	es 2□ No
of V	Physical this ce al direc	To B	examiner?	lospital: 1 🗌 Inpatien	et > ER/Outpa	tient 3 DOA	205		ence 6 Other (Sp	pecify)
	ling Ph	lon:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day	Year) 28b. Tim	y Wo		28d. Describe he	ow injury occurred	
Division	or Attending after death. Director: After in by the fune	ertification;	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e Place of Inju	ry - At home, farm	M 1 =	Yes 2 No	28f. Location (S	treet and Number or	Rural Route Number
Ε̈́	al or a safter 1 Direction by	erti	4 Homicide determined	building, etc.	(Specify)	street, factory, office		City or Town	n, State)	riara riodio rvambor,
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical C	29a. Certifier Certifying Phys	sician: To the best of ner: On the basis of e	f my knowledge, d	eath occurred at the ti	me, date and place,	and due to the c	ause(s) and manner	as stated.
	the H hin 24 the F nplete	Medi	one)	and manner state	ed.					
V.	Veiti To	-	29b. Signature and title of certifier			29c. Licen:			9d. Date signed (Mo	nth, Day, Year)
Y	10		30. Name and address of person who co	ampleted cause of do	ath (Item 22a) /T	D.1-1)	57600		6/1/04	
1	20		31. Date filed (Month, Day, Year) JUN 0 2 2	ST Has	とかしろく	1D 21740	•			
	Sta		31. Date filed (Month, Day, Year)	1) A 32. Redistrar	's Signature	Spell				
	Registr	ar	JUN U Z Z	JUL A		/				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend Item #26 State of Maryland / Department of Health and Mental Hygiene State Registrar WCHD/SH 6/2/04 per Dr. Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 10 **Physician** Starleber Times milton 2043 PM 2004 Mor 27 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City,/Town, or Location of Death 4c. County of Death Examiner (Nashin aunt If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth March 14,1960 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Min 1 XM 2□ F Months Hours Maryland 44 217-76-7115 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Madical Examiner must be notified at 1 ▼Yes 2 No Director Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 9714 Garis Shop Road 21740 U.S.A. or flems 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ If Yes, Give Year or Dates: 3 Widowed 4 Divorced "neturef" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Trucking Company Truck Driver 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental H James Milton Starleper, Sr. Betty Embly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 is m any injury or other traum <u>2005</u>s. Anna M. Starleper/Wife 9714 Garis Shop Rd. Hagerstown, MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🎇 Burial 2 □ Cremation 3 □ Removal from State 6/2/2004 Rest Haven Cemetery `4 Donation 5 Dother (Specify) Hagerstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave. Hagerstown, MD 21742 S.Marse Su 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Athrosclerof, L Physician Cordiavasulas /Medical Due to (or as a consequence of) Examiner tinsi va Sequentially list conditions, Die to for as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury use as the burial-transit requires that the death certificate be executed DLOSIT that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? (es No certificate 1 Yes Physicien: director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 2 No ER/Outpatient 3 DOA 1 🗌 Yes 1 Inpatient Posidence 6 Other (Specify) funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred To the Hospitel or Attending Natural 2 Accident 5 Pending after death. Director: A investigation 6 Could not be determined 3 🗋 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a Funerel L 29a. Certifier 💢 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) within 2 To the 29b. Signature and little of certifier MP, FRAEM D005696 Stephen Kotch

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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			_ For			artment of Heal		•	ene	00001
		111	1 - State Registrar		Cei	rtificate of Dea	ath	Reg	2 U 0 4	20024
	Physici		1. Decedent's Name (First, Middle, Last) Trig Olen Stancil	. Sr.				2. Date of Death Month June	Day Year 7 200	
	/Medio Examir		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or Loca	ition of Death		4c. County of De	
			1901A Jefferson P			Knoxvil			Freder	
	Funeral Director		5. Social Security Number 237-66-5183 Usual Residence of Decedent 6. Sex 1	_	o yrs. last birthday) 62 Yrs.		nder 24 Hrs. burs Min.	8. Date of Birth (Month, Day,) Mar 21 1	(ear) 9. B (942 No:	othplace (State or Foreign Country) rth Carolina
	yland		10a. State 10b. County	10	c. City, Town or Lo	ecation	-			10d. Inside City Limits
	e Mar	ctor	MD Frederic	ck	Knoxvill	e				1 ☐ Yes 2√2 No
	death with the Maryland ms 23a or 28a-f ehow Entrest for mulfilled at	ai Director	10e. Street and Number 1901A Jefferson Pi	ike		10f. Zip Code 2175	8	100	g. Citizen of What C USA	Country?
	2 should be filed within 72 hours after death with the Marylan and Menial Hyglene. Is marked other than 'naturel', or items 23a or 28a-f show aumatic event, II.a Medical Exactinating the indiffer a	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ★No If Yes, Give Year or Dates:	ı	Was Decedent of Hispan If Yes, specify Cuban, Me 1 ☐ Yes 2 🎛 No Spe	ic Origin? (Spec exican, Puerto P ecify:	cify Yes or No- lican, etc.)	14. Race - Am Black, Wh Specify:	
- - -	72 ho natur	eted	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	dent's Usual Occupation kind of work done during	most of workin	g 16	6b. Kind of Busines:	s/Industry
121	within	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired) penter			Constru	ation
א ס	filed Hygid Other	Be Co	17. Father's Name (First, Middle, Last)		- Cai	•	Mother's Name	(First, Middle, Ma		iction
lan I	Aental Aental rked o	To B	William Jackson St	ancil			Lora N.	Taylor		
lary	is 1 and 2 should of Health and Men item 27 ie marke other traumatic		19a. Informant's Name/Relationship (Typ			ng Address (Street and N				
	1 and Health tem 27 other tr		Mary R. Stancil, V			A Jefferson	Pike, I			
בַ	Pages 1 nent of H int: If ite iry or ot		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	moval from State	-	natory or other place)	6/12/		c. Location - City o	
Baltimore,	permit. Pages Department of Important: If it any injury or once.		*4 □Denation 5 □ Other (Specify) 21. Signature 17 peral/Service License	the state of the state of		Lle Heights . Name and Address of F		04 1	Brownsvil	ie, mi
Ä	Dep Imp		Francia IT	liams, Owne	~	John T. Wil 100 Petersy	liams Fu	uneral H	ome	21716
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C. Box	w requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-transit	by Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	ic. If yes, outcome of p 1 Live birth 2 4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
J.	requires that the neen signed by th hould be detache	Ph	Part II. Other significant conditions cont	ributing to death but no	ot resulting in the un	nderlying cause given in F	Part I.	23e. Did tobac	cco use contribute t	o the cause of death?
Vital Records,	quires an sigr uld be							1 ☐ Yes	2.XNo 3□P	robably 4 Unknown
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<u>r</u>	The ate h page	Соп						performe	d? death?	2 No
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0	nding Phath. ath. r: After thi	atloi	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Ye	ar) Injury	Work? M 1 ☐ Yes	2 □No			
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	e Hospit 24 hours e Funere letely fille	edical (29a. Certifier (Check only one) Certifying Physical Certifier P	cian: To the best of me er: On the basis of exa and manner stated.	y knowledge, death mination and/or inv	occurred at the time, dat restigation, in my opinion,	te and place, and death occurred	d due to the caus I at the time, date	e(s) and manner as and place, and due	s stated. e to the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier			29c. License num	ber	29d.	Date signed (Mont	h, Day, Year)
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	1		30. Name and address of person who con Elhamy ESK-avider		(Item 23a) (Type, I	Print) A Chart	Fred	erick,	MD 2	1701
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		1 - State Amend#29dpe		SL, 0/1	1/6/4	HIICALE OI		R. Date of Deat	eg. Ng. U	3. Time of Death
Physicia		1. Decedent's Name (First, Middle, Last						Month June	Day 2004	8100 AM
/Medic	al	Elvin Shiffle				4h City Town o	r Location of Death	Juine	4c. County of Dea	
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		5. Social Security Number 6. Se		(In yrs. last bir	thday)_	If Under 1 Year	If Under 24 Hrs. 8	B. Date of Birth	9. Bi	thplace (State or Foreign
Funeral Director			XM 2□F	71	Yrs.	Months Days	Hours Min.	(Month, Dey,		ountry) rginia
		Usual Residence of Decedent		1 -						-,
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Ba-f s	Director	Maryland Frederic	k	Fre	eder					21
ith th		10e. Street and Number				10f. Zip Code		,	0g. Citizen of What C	ountry?
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er de Items	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		13. W	Yes, specify Cub	lispanic Origin? (Spec an, Mexican, Puerto Ri	ican, etc.)	Black, Wh	
rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 ☐ Yes 2 📆 N If Yes, Give Year or Dates:	0	1	□Yes 2∏XNo	Specify:		Specify:	White
72 hours "natural",	B	15. Decedent's Edi		16a.	. Decede	ent's Usual Occup	pation		16b. Kind of Busines:	1120-20
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yiene.	Completed	8	College (1940) 34	r)	At	tendant			Service S	tation
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nould be Mental narked c	To B	Simmie Shiffle	tt				Mamm	ie Shi	fflett	
shou and N		19a. Informant's Name/Relationship (T	ype, Print)	19b	o. Mailing	Address (Street	and Number or Rural	Route Number	r, City or Town, State,	Zip Code)
permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene Important: If item 27 la marked other than "naturany injury or other traumatic event, II a Madical once.		Charlotte S. Brit	t - Former		839	7 Willia	ms Drive.	Freder	rick, Mary	land 21704
of He of He liter		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 ☐	Personal from State	20b. Place o cemete	of Dispos Pry, crem	ition (Name of atory or other pla	ce) Da	te	20c. Location - City o	r Town, State
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permit. Pa Departmen Important: any injury		21. Sign ture of Funeral Serve Licens	() (·		0^{22}	Name and Addre	ess of Facility Lesworth P	.A. Fı	uneral Hom	e
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ician: Th certificate rector, pag	e Co	25. Was case referred to medical					26. Place of Death		2 ∑√ No 1 ☐ Y€	s 2 E No
nyaician: nis certifica I director, p	o Be	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatie	nt 2 ER/O	utnatient	t 3□ DOA Ot	hor		ence 6 □Other (Sp	ecify)
Phy r this	-	27. Manner of Death	28a. Date of Injur (Month, Day		Time of	28c. Inju			ow injury occurred	
iding Phi th. : After thi s funeral	ê	1 Natural 5 Pending 2 Accident investigation		(Year)	Injury		Yes 2 No			
Atter dea	fica	3 ☐ Suicide 6 ☐ Could not be	288. Place of Inju	ry - At home, f	arm, stre	eet, factory, office	28	Bf. Location (S City or Tow	treet and Number or I	Rural Route Number,
afte afte	Certification;	4 Homicide	building, etc	э. (Specily)				Ony or You	,, Siaro)	
To the Hospital or Attending Phyaician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the burn		29a. Certifier 1 Certifying Ph	ysicien: To the best of	of my knowledg	ge, death	occurred at the t	ime, date and place, ar opinion, death occurre	nd due to the d	ause(s) and manner	as stated.
n 24 ha Fu	edical	(Check only 2 Miedical Exen	and manner sta	examination at	na/or inv	restigation, in my	opinion, death occurre			
To the To the To the Comp	ž	29b. Signature and title of certifier	1 - 6 - 6	•		29c. Licen	se number	2	29d. Date signed (Moi	nth, Day, Year)
		M H-2-	HEGA	-ZI,N	10	O.	44104		0141	06/07/04
_		30. Name and address of person who	completed cause of d	eath (Item 23a)	(Type, I	Print)	1 1100	17.0	A. >	HERAY
5		46 B Thomas	Johnso	.0.	-6		de MD2	1/02	. 17.2	110514
	ate	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature		6 1	nks			
Regist	rar	ALM 14	2004 50	marin	F	1 100	reks!			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Yeer Physician 4, М George C. Smith June 2004 4:50a /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner 24308 Kaykae Drive Montgomery Damascus If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country) 5, Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 2 M 2 □ F 29, Yrs 1928 75 Florida Director 247-42-1045 Usual Residence of Decedent 10b. County 10d, Inside City Limits 10c. City, Town or Location 10a State 1 ☐ Yes 2 No Director Maryland Montgomery Damascus 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 24308 Kaykae Drive 20872 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Amed Forces:

1 XYes 2 No
If Yes, Give
Year or Dates: Korean 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: 2 Specify. 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Accounting 4 Accountant 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Meiden Surname) Be Ruby_Coleman Marvin Loami Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24308 Kaykae Drive, Damascus, Maryland 20872 Delores N. Smith/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 6/8/2004 Germantown, Maryland ⁴ 4 □ Donation 5 □ Other (Specify) All Souls Cemetery 21. Signature of Funeral Service Licensee Olin L. Molesworth P. A. Funeral Home 26401 Ridge Road, Damascus, Maryland 208/2 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on-course on each line. Approximate Interval Between Onset and Death Parmonery Immediate Cause (Final UDSTRUCTIV1 hrunic Dissam **Physician** resulting in death) /Medical Due to (or as a consequence of) **Examiner** F. brusi PermonARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequ nce of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) the attending physician Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 ☐No 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. peq 3 Probably 4 Unknown Nes 2 No Hypertensio been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performe 2□ No certificate 1 Yes 2 No 1 Tyes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 2 No this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28c. Injury at Work? Certification: After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death after death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 0 within 24 hours 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier 0 A ISAII 408ML P 2331 JUNE 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

10+1

State

Joseph Ball 31. Date filed (Month, Day, Year)

JUN 0 8

Division of Vital Records, P.O. Box 68760,

Gaithersburg, Maryland

Suite 213

M.D. 16220 Frederick Road,

32. Registrar's Signature

			For	State of N	Marylan	d / Depa	artment	of He	alth a	and Me	ental Hyg	jiene	.09.2.0.	
			1 - State Registrar			Ce	rtificate	of D	eath		F	Reg. No.	004	20027
	Physici	an	Decedent's Name (First, Middle	e, Last)							Date of Dea Month	ith Day	Year	3. Time of Death
	/Medic	al	Bonnie	Sue	SMITH	I	4b. City, To	um or l	costice o	4 Dooth	June	1.		
	Examin	er	4a. Fecility Name (If not institution Garrett Count			1	4b. City, 10	wn, or L		land		40.0	County of Dea	rett
	Funeral		5. Social Security Number	6. Sex 7. /		last birthday)	If Under 1 Months	Year Days	If Under	24 Hrs.	8. Date of Birt!) (Vear)	9 Bir	rthplace (State or Foreign ountry)
	Director		216-74-5215	1 □ M 2 🖾 F	46	Yrs.	Months	Jays	Hours]	(Month, Day Feb. 15	, 19	58 M	laryland
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	ocation							10d. Inside City Limits
	Mary a-f sh	tor	MD	Garrett			Sv	vant	on					1 ☐ Yes 2 ☒ No
	ith the	Oirec	10e. Street and Number				10f. Zip C					10g. Citiz	en of What C	ountry?
	s 23e	Funeral Director	685 O'Brien R	oad 12. Was Decede	nt Francis II	F 12	Man Decede		561	-i=2 (Cnoo	it. Ves or No	14	USA 4. Race - Am	oriona Indian
	fter de ritem inerri	Fune	11, Marital Status 1 □ Never Married 2 □ Mar	ried Armed Force	s?				, Mexican	, Puerto R	ify Yes or No- ican, etc.)	'	Black, Whi	
036	rat', o	<u>م</u>	3 ☐ Widowed 4 ☼ Divorced	If Yes, Give Year or Date:	s:		1 ☐ Yes 20	J No	Specity:			5	Specify:	White
21215-0036	within 72 hours after death with the Maryland ene. Than "natural", or items 23e or 28e-f show he M. Jical Examirer must be molified at	Completed		nt's Education est grade completed)		(Give	dent's Usual (kind of work DO NOT use	done du	ion ring most	of working	g	16b. Kin	d of Business	/Industry
72	withir iene. than	dwo	Elementary/Secondary (0-12) 12th	College (1-4c	or 5+)	me.		owne	r				Stab1	es
פ	e filed Il Hyg other	BeC	17. Father's Name (First, Middle,	Last)			00 .			r's Name	(First, Middle,	Maiden S		
ylar	Menta Menta arked	ToE	Daniel	Frederick	0 t	to, S				nces		ores		ugh
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If item 27 is marked other than *naturat; or items 23e or 28e f show amy original resoluter results be notified at any injury or other traumatic event, the Maclical Examiner must be notified at once.	Y 3	19a. Informant's Name/Relations								Route Numbe			Zip Code)
ē,	Healt Healt tem 2	1	Frances D. Ot 20a. Method of Disposition	to/Motner	20b. P	lace of Dispo	sition (Name	of	- 1-	Da	ton, M		ation - City or	Town, State
Baltimore,	Pages ent of nt: If i		1 ⊠ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		te	•	matory`or othe w Ceme t		!	6/13/	2004	Oak	land.	Maryland
alti	permit. Departm Importe any inju		21. Signature of Funeral Service	presente /							wart F			
	SQE = 9	0.0	- Stedly	1. seother							kland,		21550	
		8 3	23a. Part1. Enter the disease of shock, or heart failure. List Immediate Cause (Final	only one cause on each	ine.							est,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	statio		inoma (of t	he 0	varie	S			Months
	Examiner		Convention lies conditions	b										
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		as a consequ	uence of):								
	xecute and al-tran	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or	as a consequ	uence of):								
68760,	ate be executed hysician and the burial-transit	ical		d										
68		Medi	IF FEMALE:											
Вох	death certifica e attending ph id for use as t	ian/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcon 1 ☐ Live birth	2 Fetal	Ideath 3[⊒Ectopic preg					23	Bd. Date of de Month	livery Day Year
0		Physician/Med	1 □ Yes 2 ☑ No 9 □ Unknown	4☐Pregnant 9☐Unknown		eath 5L	Other (spec	ify)						,
<u>α</u>	law requires that the as been signed by th 2 should be detache	by Ph	Part II. Other significant conditi	ons contributing to death	but not resi	ulting in the u	nderlying cau	se given	in Part I.		23e. Did to	bacco us	e contribute to	the cause of death?
ords	w require been sig should b										1 🗆 Y	es 2 ∏	No 3□P	robably 4 Unknown
Records,	law re las be	Completed									24a. Was a	sy	24b. Were a	utopsy findings available completion of cause of
al H	n: The icate ha											2 🔯 No	1 Yes	s 2□ No
Ž	Physicien: this certific ral director,	To Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☒ No	Haspital	atient 2	EB/Outnatier	nt 3□ DOA	Othon			(Check only or e 5 ☐ Resid		Other (Sne	acity)
ם נ			27. Manner of Death	28a. Date of I		28b. Time o		. Injury a Work?	1 1 1 1 1 1 1 1 1	-	d. Describe h			<i>Unyy</i>
sior	Attending r death, ector: After by the fune	catic	1 Natural 5 Pendi 2 Accident invest 3 Suicide 6 Could	igation	,,	,,	М		es 2⊡ñ					
Division of Vital	in the	Certification;	4 Homicide determ	ained 288. Place of	Injury - At ho etc. (Specif)	ome, farm, str V)	reet, factory, o	office		28	If. Location (S City or Tow		Number of R	ural Route Number,
	To the Hospitel within 24 hours a To the Funeral Completely filled		29a. Certifier	ng Prysicien: To the be	st of my kno	wiedge, deat	h occurred at	the time	, date and	d place, ar	nd due to the c	ause(s) a	nd manner a:	s stated.
	he Ho in 24 I he Fu pletely	Medicai	one	eminer: On the basis and manner	s of examinat stated.	tion and/or in	vestigation, in	my opir	nion, deat	th occurred				
	Vith To t	Σ	29b. Signature and title of Ceptific	ır I			29c. L	icense i	number		2	9d. Date	signed (Mont	
			30 No.	uha ana ilahad assa	of closes /se-	199) /T	Print'	D	2397	9			6/11/	2004
		4	30. Name and address of person Robert A. Gor	alski M. D				St.,	0ak	land,	Md. 2	1550		
	Sta	te	31. Date filed (Month, Day, Year) 32. Regi	stre's Signa	ture	A							
	Registr	ar	JUN	1 1 2004	Popular.	B	A south	20						

			For Stata Ragistrar	State of N	/larylar		artment rtificate			nd M	lental Hygi	iene 19. NG. N	1.	20020
	Physicia	an	Decedent's Name (First, Middle, La	•	D = === C	anith					2. Date of Death Month	Day	Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, gir	William 2		шш	4h City T	Town or	Location of	Death	June	09, 2004 4c. County	of Death	5:00A. M
ſ	Examin	er		8 Jackson Str			40.00,	01111, 01		nacoi	inα			gany
	Funeral					last birthday)	If Under		If Under 2	4 Hrs.	8 Date of Birth	Voorl	9. Birth	place (State or Foreign
	Director		215-26-7001	Sex 7 12 M 2□F	78	Yrs.	Months	Days	Hours	Min.	(Month, Day, April 22,			mtry) Maryland
	D.		Usual Residence of Decedent		140									104 4-14- 0'0-11-15
	ahow	۰	10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside City Limits 1 X Yes 2 □ No
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	vith th	Ę	10e. Street and Number				10f. Zip	Code			10	0g. Citizen of		
	s 23e	rai		kson Street	at Ever in I	18 12	Mas Doods	ont of Hi	21539	in? (Sne	oify Vac or No-	14 Bar	USA ne - Ameri	A can Indian,
36	within 72 hours after death with the Maryland ene. then 'natural', or items 23e or 28e-f show ts Malical Examinar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Force 1 XYes 2[If Yes, Give Year or Date	s? ⊒No	i	If Yes, speci	_/	n, Mexican, Specify:	Puerto	ecify Yes or No- Rican, etc.)		ck, White,	
21215-0036	atura	ed	15. Decedent's E			16a. Dece	dent's Usual	Occupa	ation	, ,		16b. Kind of B	usiness/Ir	
75	7 nin 7	Completed	(Specify only highest gi	rade completed) College (1-4d	or 5+)	(Give life.	kind of worl DO NOT us	k done d e retired	during most (of worki	ng			
212	filed with Hygiene ither the	E	12	0				Pa	per Mill				True	ck
	should be filed withir of Mental Hygiene. marked other then imatic event, II.s. M	Bec	17. Father's Name (First, Middle, Las	t)					18. Mother	's Name	(First, Middle, N	Aaiden Sumar	ne)	
Maryland	should be and Mental marked o umatic eve	10		Thomas Smi	th	_					Jennie	e Roberts	on	
an	2 sho and I is me		19a. Informant's Name/Relationship			19b. Maili	ng Address	(Street a	and Number	or Rura	ai Route Number,	City or Town	State, Zi	o Code)
	s 1 and of Health item 27 other tr		Edythe S	mith	Too.				son Stre	-	onaconing			
ore	ges 1 of H		20a. Method of Disposition 1. ■ Burial 2 □ Cremation 3	Removal from Sta	1 1	Place of Dispo cemetery, crea	natory or ot	ne of ther plac	e)		une 11,	20c. Location	- City or I	own, State
Ĕ	Pages ment of ent: if it		*4 □Donation 5 □ Other (Spec	ify)		Frostbur					2004	Frost	burg 1	Mary land
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene Importent: if item 27 is marked other then "naturary injury or other traumatic event. If a Mulical Office."		21. Signature of Funeral Service Lice 21. Signature of Funeral Service Lice 22. McKe	and a]	Eichh		Kenzi	e Funeral H		. 8 E. I	Main
8760,	water be executed hysician and hysician and the burial-transit	Ical Examiner	Speck, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to stime-disting cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or b. Due to or	as a co. sec	quence of): rec Ke quence of): C VSC	Disci Penal Penso	fa	mat;	îcn				Interval Between Onset and Death
P.O. Box 68	law requires that the death certiticate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcon 1 ☐ Live birth 4 ☐ Pregnan 9 ☐ Unknown	2 Fet	al death 3	⊒Ectopic pre ⊒ Other (spe						ate of delive	rery Day Ye <i>a</i> r
	uires that signed b id be deta	by	Part II. Other significant conditions	contributing to deat	f but not re	~ 1	inderlying ca	ause giv	en in Part I.		23e. Did tob	V	tribute to	the cause of death? bably 4 □Unknown
Division of Vital Records,	icien: The law requir certiticate has been s' rector, page 2 should	Completed	- Longestin	Cadias	fai	lye				_	24a. Was a autops perform 1 Yes 2	v	Were aut prior to co death? 1 \(\sum \text{Yes}	opsy findings available ompletion of cause of
ital	rtiffica	Be C	25. Was case referred to medical						26. Place	of Deat	h (Check only on	e)		
<u>_</u>	Physicien: this certition ral director,	To E	examiner? 1 ☐ Yes 25 No	Hospital: 1 ☐ Inp	atient 2	ER/Outpatie			4 🗀 (40)				ner (Spec	ify)
ion o	Jing n. After fune	ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigati	on	njury Da <i>y Year)</i>	28b. Time o Injury	of 2	8c. Injun Wor 1 🗀	yat k? Yes 2 □ N		28d. Describe ho			
Divis	tet or Atters of safe or a	Certification;	3 Suicide 6 Could not 4 Homicide determine	d 289. Place of	Injury - At I etc. (Spec	nome, farm, st ify)	reet, factory	, office			28f. Location (St. City or Town	reet and Num n, State)	ber or Rui	al Route Number,
	To the Hospitet or Attenwithin 24 hours after deatl To the Funerel Director:	edical	29a. Certifier 1 Certifying I (Check only one) 1 Medical Ex	Physician: To the be aminer: On the basi and manner	s of examin	owledge, dea ation and/or in	th occurred anvestigation,	at the tir in my o	ne, date and pinion, deatl	d place, h occur	red at the time, d	ate and place,	and due	to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	1.1			290	Licens	e number	7/0	2	9d. Date signe	ed (Month	Day, Year)
)	8/10/	7	N.H.	Kan 15/ hay	7				1172	18		Ju	ne j	11 2003.
-	nds			THAN M	D. J		Print) Utow	nh	ROAD,	Cu	mberlano	l, ma	ry/m	1/2 200 J.
	St Regist	ate rar	31. Date filed (Month, Day, Year) JUN 1 0 2004		istrar's Sigr معمر	nature	Span	ls/	,			-		

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 3. Time of Beath 2. Date of Death **Physician** Day SARAH NELLIE SNELSON 31, 2:10AM MAY 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death ST VINCENT de PAUL NURSING CENTER FROSTBURG ALLEGANY 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 X F Director 214-07-2379 20-Oct-1916 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or items 23e or 28a-f show other traumatic event, the Modical Examinar must be notified at Director 1 Yes 2 □ No Maryland Allegany Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 100 Honeysuckle Lane Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. and Health and Insure 1,3 marked other than "natural", or Hems 23. 21532-12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 12 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify 3 XWidowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 technician medical hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ William Eisel Nellie Brode 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 408 Crest View Drive Gerald Snelson Frostburg Maryland 21532-20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ★Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If any injury or once. Cumberland Crematory 01-Jun-2004 Cumberland Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility our Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Duodenal **Physician** Metastatic disease or condition resulting in death) 3 month /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): Hospitel or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit nding physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ▼ No 24a. Was an autopsy performed? certificate 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: Certification: To 1 ☐ Yes 2 📉 No · this 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) worsolesten MO D0055325 6 June 01, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WONSOCK SHEW 48 Tarn Frostburg, MD21532 MD Terrace 31. Date filed (Month, Day, Year)
JUN 0 1 2004 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ack

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 8:00 PM **Physician** Ida Elizabeth Snyder 04 30 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner SACRED ALLEGANY HOSPITAL UMBERLAND HEART If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F 220-10-1771 83 Director July 01, 1920 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits other then "neturel", or Items 23e or 28e-f show vent, the Nedical Exert is a must be notified at 1 Yes 2 No Director Maryland Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12824 Meadow Avenue 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify þ 3 ✓ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Green Mary Dawson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlene Horning/Daughter 12819 Lewis Hgts. Drive, S.W., Cumberland, Maryland 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State June 03, Green Cemetery injury * 4 ☐ Donation 5 ☐ Other (Specify) 2004 Lonaconing Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A. 8 F. Main 23a. Parl . Enter the disease, or complications that a used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final disease or condition resulting in death) 10 days **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Cher (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 3 Probably 4 Donknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? Overme Hydrocephal Hyper tension Aortic Stenons Normal 2 No 1 Yes 2 No 1 Tes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 2 ER/Outpatient 3 DOA this Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Hatural Director: 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Funerel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Janaan , M. D. 31 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CUMBERLAND MARYLAND HUSalm Semaan, M.D SACRED HEART HOSPITAL 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 0 2 2004 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Michael H. PryoR

			For	se Type or F State of		d / Depa		lealth and N		/giene	9	
		كين	Registrar 1. Decedent's Name (First, Midd	le. Last)		Cei	uncate of	Dealli	2. Date of D	Reg. No	5001	3. Time of Death
	Physici		Michael	Henry	Tho	mas	Pryor,	Sr.	Month	3 U	2004	1515 M
	/Medio		4a. Facility Neme (If not institution		ber)			or Location of Death			. County of Deal	th
			Lions Mano					erland	1000000		Alle	
	Funeral Director		5. Social Security Number 220-10-2333	6. Sex 1 ⅓ M 2 ☐ F	7. Age (In yrs. I 89	ast birthday) Yrs.	If Under 1 Year Months Days		8. Date of B (Month, D 03/25			hplace (State or Foreig puntry) ryland
and	* _		Usual Residence of Decedent 10a. State 10b. Count	/	10c. City	y, Town or Lo	ocation					10d. Inside City Limits
death with the Maryland	d sh	ŗo	MD Alle	ganv		Cur	mberland					1 ⊠Yes 2 □ No
the	r 28a	irec	10e. Street and Number	0/			10f. Zip Code			10g. Ci	tizen of What Co	ountry?
th with	23a o	ai D	19 E. Indust	rial Boule	vard		2150				SA	
ē	tal hygiene. d other than "neturel", or liems 23a or 28a-1 show event, the Modical Extrainer mast be notified at	y Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Ma	rried Armed For	2□No 194	1-	Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 💆 No	Hispanic Origin? (Sp ean, Mexican, Puerto Specity:	pecify Yes or N Rican, etc.)	0-	14. Race - Ame Black, Whit Specify:	e, etc.
hours	urel	d by	3 ∑ Widowed 4 □ Divorce	d Year or Da	ites: 194		dent's Usual Occu	nation		16h K	Cind of Business	White
Marylatid 2.12.13-0030 d 2 should be filed within 72 hours af	than net	Completed	(Specify only high Elementary/Secondary (0-12)	est grade completed)	4or 5+)	(Give life.	kind of work done DO NOT use retire Carman	during most of work	king	100.1	Rail	•
7 pell 1	Hygie theri	ပိ	17. Father's Name (First, Middle	, Last)		L	Ja I man	18. Mother's Nam	ne (First, Middle	e, Maider		Loau
y all		To Be	Jacob		Pryor			Susan	Ann	В	ridentha	all
2 should	f Health and Mer tem 27 is marke other traumatic	-	19a. Informant's Name/Relation					t and Number or Ru				Zip Code)
	n 27 i		Sharon Pryor	/ daughter	ook 5	_		y Street,	Cumbe Date			21502
- עם	nent of Hez int: If item iry or othe		20a. Method of Disposition 1 →Burial 2 ☐ Cremation				osition (Name of matory or other pla	ocky Gap (ocation - City or	
ICITAL It. Pa	Department of Important: If it any injury or one		* 4 ☐ Donation 5 ☐ Other (21. Signature of Funeral Service		ITL							Home, P.A
Baiti	Depa Impo any ii		21. Signatura of Piliteral Service		1			ur Street		_		21502
			23a. Part1. Enter the disease, c shock, or heart failure. Lis	or complications that co	aused the deat	h. Do not en	er the mode of dy	ing such as cardiac	or respiratory	arrest,		Approximate Interval Between
Pn	ysician		Immediate Cause (Final disease or condition	Lali	110.1	mcul.	ani	failu	9			Onset and Death
/1	Medical		resulting in death)	a. Dus-to (or as a conseq	uence of):		1				
Ex	caminer		Sequentially list conditions,	b. 150	haen	ic t	Kant	disea	26			5 years
pe	sit	inei	Sequentially list conditions, if any, leading to immediate cause. Litter or denying Cause (Disease or injury	Due to (or as a conseq	uence of):						- (
J, executed	an and rial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a conseq	uence of):						
		1		d								
68/	g phy: as the	edic		<u> </u>	-						Politica.	
Records, P.O. Box 6876 The law requires that the death certificate be	ed by the attending physician detached for use as the buria	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		inth 2 ☐ Fete ant at time of d	Ideath 3	□Ectopic pregnand □ Other (specify) _	ey .			23d. Date of de Month	livery Day Year
that t	deta	y Ph	Part II, Other significant condi	tions contributing to de	eath but not res	ulting in the t	underlying cause g	ven in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
rds quires	s been signed t should be det	ed b	5/1 white	M. L. CC	27-D	177	pertens	sion	1,58	Yes 2	No 3□P	robably 4 Unknow
Vital Records, sicien: The law requires t	as bee 2 sho	plet	Konal	insuff	ccelli	Cy!			24a. Wa	opsv	prior to	utopsy findings availab completion of cause of
The I	ate has page 2	E O		N)					per 1 ☐ Yes	formed?	death? 1 ☐ Yes	
/ita	ertific	Be (25. Was case referred to medic examiner?	-				26. Place of Dea	1100	4		
of Vita Physicien:	this c	5	1 Yes 25 No	Hospital: 1 🔲 I		ER/Outpatie 28b. Time of	Int 3 DOA		ome 5 ☐ Re		6 ☐Other (Spe	ecify)
E gi	After funer	tion	27. Manner of Death 1 Natural 5 □ Pendinye	(Mont	h, Day Year)	Injury	We	ork?]Yes 2 □No	200. 2000		.,	
Division of	24 hours after death Funeral Director: Itely filled in by the	Certification:	3 Suicide 6 □ Coul	d not be 28e. Place	of Injury - At h	ome, tarm, si fy)	treet, factory, office			(Street a own, Stat		ural Route Number,
]		Medical C	29a. Certifier 15 Certify (Check only one)	ring Physician: To the al Examiner: On the band man	best of my kno asis of examina ner stated.	owledge, dea ation and/or i	th occurred at the investigation, in my	time, date and place opinion, death occu	, and due to th irred at the time	e cause(s e, date an	s) and manner and place, and du	s stated. e to the cause(s)
To th	within To the	Me	29b. Signature and title of certif	ier] [se number		-	ate signed (Mon	th, Day, Year)
11	IVA		V. A. Ko	injethan			DI	9750		Ji	ine 1	,2004-
1			30. Name and address of person					01	- d MD		*	
7/1			V . A . K	A Withan	51 7 Legistrar's Signa		own Road,	Cumberla	and, MD	21	502	
	St Regist	ate	31. Date filed (Month, Day, Yea		a L	1 1	sould					

DHMH 17 Rev 1/2001

State Registrar

JUN 0 1 2004

JB5 State

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

State Registrar 31. Date filed (Month, Day, Year)

JUN 1 4 2004

32. Registrar's Signature of Specific

			1 - For Stete Registrar		epartment of Health and Certificate of Death		0.0	
ř			1. Decedent's Name (First, Middle, Last)		2. Date of Death	- CUU4	3Time of Desath
5	Physici /Medic		Dorothy	Louise	Sweetney	May 29,	2004 ^{ear}	2344 M
100	Examir	er	4a. Facility Name (If not institution, give Prince Georges		4b. City, Town, or Location of Dea		4c. County of Death Prince Ge	orgos
160	Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs. last birth		s. 8. Date of Birth	9. Birthpl	ace (State or Foreign
ère	Director		215-56-9691 Usual Residence of Decedent	□M 2MgF 56 Y	rs. Worters Days Frours Will	May 29,	948 Wash	Ington, DO
	yland		10a. State 10b. County	10c. City, Town	or Location		10	Od. Inside City Limits
	Be-f s	ctor	Maryland Prince	Georges Brand	ywine			1 X Yes 2 □ No
	death with the Maryland ms 23s or 28e-f show frount be rediffed at	Dire	10e. Street and Number 17821 Horsehead	Road	10f. Zip Code 20613		Citizen of What Count	try?
	death	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue		14. Race - America	
36	be filed within 72 hours after death with the Marylan ital Hygiene. In the last state of other than "naturel", or Items 23a or 28e-f show event, it a Madical Examirer must be notified at	by Fu	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 No If Yes, Give	1 ☐ Yes 2 No Specify:	rto Hican, etc.)	Black, White, e	
21215-0036	2 hour	ed b	3 XWidowed 4 ☐ Divorced 15. Decedent's Edu	Year or Dates:	Pecedent's Usual Occupation	16b	Specify: Bla	
215	within 72 ene. than "n	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	Give kind of work done during most of wo ife. DO NOT use retired)	orking		•
	filed with Hygiene other tha		12 17. Father's Name (First, Middle, Last)	Cu	stodial Worker		deral Gov	vernment
Maryland	should be find Mental be marked of	To Be	Joseph R.	Thomas	Gladys	me (First, Middle, Maid	arper	
ary	2 should by and Menta Is marked sumatic ev	<u></u>	19a. Informant's Name/Relationship (T)		Mailing Address (Street and Number or R			Code) 20613
	1 and 2 Health em 27 I		Franklin Thomas	Driver/Son 17	821 Horsehead Ro	oad Brand	ywine,Mar	ryland
Baltimore,	Se to to		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	lemoval from State cemetery,	Disposition (Name of crematory or other place) rection Cem Jur	2004	Location - City or Tov	
attu	permit. Pag Department Importent: I any injury o	P	4 ☐ Donation 5 ☐ Other (Specify)21. Signature of Funeral Service Licens		22. Name and Address of Facility	10, C1	inton,Mar	yland
ñ	Departing Department of the policy of the policy in the policy in the policy of the po	l l	Odessa O	Her M01323	Adams Funeral H	Home P.A.	Aquasco,	Maryland
	K.		snock, or heart failure. List only of	ications that caused the death. Do no ne cause on each line.	t enter the mode of dying, such as cardia	c or respiratory arrest,		Approximate Interval Between
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	MyoCarda	1 infarelian			Onset and Death
	Examiner			Due to (o) as a consequence of	and some he	îl		
	p #	iner	flany, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of)	occord per	cuy		
_	xecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of)	ectory disea) e		
68760,	ficate be executed physician and s the burial-transit	calE	L.	1	1			
_	rtificat ng phy as the	Medical	IE EFMALF.					
Box	The law requires that the death certif Ite has been signed by the attending page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death	3 ☐ Ectopic pregnancy		23d. Date of deliver	y Day Year
л О	the de	ysic	1 ☐ Yes 2 🗖 No 9 ☐ Unknown	4☐ Pregnant at time of death 9☐ Unknown	5 Other (specify)		MONUTE L	Jay rear
ر ت	ires that signed by be deta	by Ph	Part II. Other significant conditions con	ntributing to death but not resulting in the	ne underlying cause given in Part I.	23e. Did tobacco	o use contribute to the	cause of death?
ğ	w require been sig should b	ted b	end stage 8	enal disease		1 ☐ Yes	2 KNo 3 ☐ Probal	bly 4 □Unknown
ပ္တ	e law r has be je 2 sh	Completed				24a. Was an autopsy	prior to com	sy findings available pletion of cause of
<u>a</u>	certificate rector, pag		05 W			performed?		□ No
Ξ	Attending Physicien: The ri death. ector: After this certificate h. by the funeral director, page	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	lospital: 1 Inpatient 2 ER/Outp	04	ath (Check only one) Home 5 Residence	6 □Other (Specify)	
Division of Vital Records,	문 두 교		27. Manner of Death 1 ★Natural 5 □ Pending	28a. Date of Injury 28b. Tim (Month, Day Year) 28b. Tim	ne of 28c. Injury at	28d. Describe how in		
20	or Attending after death. Director: After in by the funer	icati	2 Accident investigation 3 Suicide 6 Could not be		M 1 ☐ Yes 2 ☐ No			
2	- 9 -	Certification:	4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	City or Town, Sta	and Number or Rural i ate)	Route Number,
	lospite hours unerel iy filler		29a. Certifier 1 Certifying Physical Check only 2 Medical Exemin	sicien: To the best of my knowledge, o	leath occurred at the time, date and place	a, and due to the cause	(s) and manner as stat	ed.
	To the Hospitel or within 24 hours at To the Funerel Di completely filled in	Medicai	one)	and manner stated.	or investigation, in my opinion, death occu	irred at the time, date a	nd place, and due to the	he cause(s)
	0 W I		29b. Signature and title of certifier	N Dag	29c. License number	29d. D	Date signed (Month, Da	ay, Year)
			30. Name and address of person who co	mpleted cause of death (Item 23a) (Tv	60339		0/01/20	04
i	Bh	2.5	KHALID ASHAI,	MD 3001	HOSPITAL DRIVE	CHEVE	RLY, MD	20185
	Sta Registr		31. Date filed (Month, Day, Year)	32. Redistrar's Signature	South &			

		1	For State	State	of Maryla		artment of H		nd Men		ene . No.	
Ç -			Registrar 1. Decedent's Name (First, Middle	, Last)			timodio or i			Date of Death Month	Day O Quar	3. Time of Death
Ø.	Physicia /Medic		Anna Sweiger								2004	11:15A M
	Examin		4a. Facility Name (If not institution	, give street and n	umber)		4b. City, Town, or	Location of	Death		4c. County of Deal	th
			533 Goosemar R		7 Ann /In	en land himbolari	Rising If Under 1 Year		4 Hrs. p	Date of Righ	Cecil	thplece (State or Foreign
n	Funeral Director		5. Social Security Number 222-42-9045	6. Sex 1 ☐ M 2 🔀 F	7. Age (III y	rs. last birthday) 48 Yrs.	Months Days	Hours	Min. (Date of Birth (Month, Day, Y uqust 2	(ear) Co	ungary
÷			Usuel Residence of Decedent						176	agust 2	7,7,50	
	rylan		10a. State 10b. County	- 40	10c.	City, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 X No
	Ba-f s	Director		Cecil		Rising	Sun 10f. Zip Code			100	. Citizen of What Co	
	with the		10e. Street and Number 533 Goosemar R	and			21911	1			USA	ranki y s
	death with the Maryland ms 23a or 28a-f show	Funeral	11. Marital Status	12. Was De	cedent Ever in	1 U.S. 13.	Was Decedent of H	ispanic Origi	in? (Specify	Yes or No-	14. Race - Ame	
	2 should be filed within 72 hours after death with the Marylan and Manial Hygiene. Is marked other then "netural", or Items 23a or 28a-f show aumatic event. If a Mexical Evantinar multi be invitibed at	by Fun	1 Never Married 2 Married 3 Widowed 4 Divorced		Forces? 5 2 X 1No Bive Dates:		If Yes, specify Cuba 1 ☐ Yes 2100No	Specity:	Ривпо ніса	an, etc.)	Black, White	hite
ğ	72 hou	ted	15. Deceden	t's Education	d)	(Give	dent's Usual Occup	during most o	of working	16	6b. Kind of Business	Andustry
21	ithin 76.	Completed	Elementary/Secondary (0-12)	1	(1-4or 5+)		DO NOT use retired	1)			Duna Hama	
22	iled w tygier ther th		17. Father's Name (First, Middle,	Last)		Home	maker	18. Mother	's Name (Fi		Own Home	
auc	d be f	To Be	Kalman Szkalak					Kati	alin I	lanu		
Maryland 21215-0036	shoul a mari	-	19a. Informant's Name/Relations			19b. Mail	ing Address (Street				City or Town, State, .	Zip Code)
Σ	and 2 palth a n 27 is		Kalman Szkalak	/Father			The same of the sa	r Road			n. MD 219	
ore	of He		20a. Method of Disposition 1 Burial 2 Cremation	3 □Removal fro	m State	cemetery, cre	osition (Name of matory or other plac	(e) 0	6-09-2	2004	Oc. Location - City or	
Baltimore,	it Pag rtment rtant: njury o		*4 □Donation 5 □ Other (S 21. Signature of Funeral Service	(pecify)	R.						lising Sun	
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked eny injury or other traumatic ev once.		21. Signature of Fulleral Service	1		1	11 S. Que	en St	R.T.	Foard sing Su	Funeral H n. MD 219	ome, P.A.
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	t caused the d	eeth. Do not en	ter the mode of dyin	ng, such as c	cardiac or re	spiratory arres	st,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a	etasta	tic	Breast	Can	001			0.100.01.0
	/Medical Examiner		Todaking in dodkin	Due	to (or as a con:	sequence of):						
	36	Jer	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying	b. Duar	to (or as a son	sequence of):		-				
P	cuted nd transit	Examiner	that initiated events	c								
8760,	eath certificate be executed attending physician and for use as the burial-transit	ai Ex	resulting in death) Last	Due	to (or as a con	sequence or):						
687	ficate physics the	edicai		d								
Вох	death certific e attending p id for use as	In/M	IF FEMALE: 23b. Was decedent pregnant		outcome of pre		Ectopic pregnancy	v			23d. Date of de	livery Day Year
.O. B	the atte	by Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		gnant at time		Other (specify)	,			Month	Day 19ai
a	res that the dei signed by the a I be detached f	y Ph	Part II. Other significant conditi	ons contributing to	death but not	resulting in the	underlying cause giv	ven in Part I.		23e. Did toba	acco use contribute t	o the cause of death?
rds										1 ☐ Yes	2 □ No 3 □ P	robably 4 Onknown
of Vital Records,	aw as b	Completed								24a. Was an autopsy perform	ed? prior to death?	utopsy findings available completion of cause of
ital		BeC	25. Was case referred to medica	ıl				26. Place	of Death (C	Check only one		
ž <	Physician: this certific ral director,	10	examiner?			2 ER/Outpatie	MIK 3 DOA				ice 6 ☐Other (Spe	icify)
	ding Ph h. After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pendi	i g	ite of Injury Ionth, Day Yea	r) 28b. Time Injury	Wo	ryat rk? ∣Yes 2.∐N		I. Describe hov	v injury occurred	
Division	ten for: the	ficat	3 ☐ Suicide 6 ☐ Could	minord 200, F k	ace of Injury -	At home, farm, s	treet, factory, office				et and Number or R	lural Route Number,
Ö	s after al Dire	Certification:	4 Homicide	bu	ilding, etc. (Sp	pecify)				City or Town,	Siate)	
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edicai (29a. Certifier 1 Certifyi (Check only one)	Examiner: On the	the best of my e basis of exar nanner stated.	knowledge, dea nination and/or i	ith occurred at the ti nvestigation, in my o	me, date and opinion, deat	d place, and th occurred	I due to the car at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	ž	29b. Signature and title of certific	er //			29c. Licens	43	~ ~	1	d. Date signed (Mon	/
,			1/1 840	Phil			1033	063	5	(16-US	07
				ford-SK	unot, M	0, 111	W. Hig.	h St,	#109 ₁	EIKH	06-08 on, MO	21921
	St Regist	ate trar	31. Date filed (Month, Day, Year JUN 1 0 200	14 See	. negistrars S	ignature	61					

			1 - For State Registrar	State of Ma	aryland / Depa <i>Ce</i>		of Health a of Death	and Menta	al Hygien Reg. N		20005
	Physici /Medio	cal	Decedent's Name (First, Middle, L. Norma L. Si) 4e. Fecility Name (If not institution, gi	mpson		4b. City. To	wn, or Location o	м _о Jur	ne 9	ay Yeer 200 c. County of De	
	Examir Funeral Director	ier	4041 Conowing 5. Social Security Number 6.	o Road	e (In yrs. last birthday) 7.2 Yrs.		ington,	MD 24 Hrs. 8. Dat Min. (Mo	e of Birth onth, Day, Yea	Harfor	d rthplace (State or Foreign country)
	σ	_	221-20-4647 Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation		Jur	30,	1931	Laurel, DF 10d. Inside City Limits 1 □ Yes 2 및 No
980	e 1 and 2 should be filed within 72 hours after deeth with the Meryland I Heelth and Mental Hyglane. Itam 27 is markad other than "natural", or itama 23a or 28e-f ahow other traumatic avant, the Medical Examinar must be redified at	by Funeral Director	MD Harfor 10e. Street and Number 4041 Conowing 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		40	10f. Zip Co	34-1369 It of Hispanic Orig Cuban, Mexican		Un	itizen of What C ited S 14. Race - Am Black, Whi Specify:	country?
nd 21215-0036	se filed within 72 ho al Hygiane. d other then "naturi avent, the Medical	Be Completed	15. Decedent's E (Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4or 5	(Give	dent's Usual C kind of work o DO NOT use tary	done during most retired) Aid	of working r's Name (First,	Nu	Kind of Business rsing n Surname)	s/industry
e, Maryland	e 1 and 2 should be if Heelth and Mental Itam 27 is marked o other traumatic ava	7	Dallas J. Ba 19a. Informant's Name/Relationship Carolyn L. Phi 20a. Method of Disposition	(Type, Print)	19b. Maili	Cono	Street and Number		Number, City	or Town, State,	21034-1369
Baltimore,	permit. Pagae 1 Department of H Important: If Its any Injury or ot ance.		20a. Method of Disposition \times Burial 2 □ Cremation 3 '4 □ Donation 5 □ Other (Special Service 12)	ify)	Harford Gard	matory or othe Memo ens 2. Name and A	r place)	Jn 14,0	04 Ab	erdee,	MD Services
1	whysicien end was executed whysicien end whysicien end whysicien end was the burlet treneft the particular transfer and was a second of the particular transfer and was a second of the particular transfer and transfe	Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List onthe timediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as b. Due to (or es	he deeth. Do not en	er the mode o	of dying, such as	cardiac or respir	atory arrest,		Approximate Interval Between Onset and Death 5 years
P.O. Box 68760,	lew requires that the deeth certificate be assecuted as been signed by the attending physicien and 2 should be deteched for use es the buriel-trensit	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 _Live birth 4 _Pregnant at 9 _Unknown	2 Fetal death 3	Ectopic pregi				23d. Date of de Month	livery Day Year
	w requires thet i been signed by should be dete	þ	, ,	contributing to death b	ut not resulting in the u	nderlying caus	se given in Part I.		1) Yes 2	!□No 3□P	o the cause of death?
of Vital Records,	The hoags	Se Completed	Osteoporosis History of luna 25. Was case referred to medical	Cancer Fi	esection		26. Place	- _	a. Was an autopsy performed? Yes 2 3 N	prior to death?	utopsy findings available completion of cause of
Division of V	To the Hospital or Attending Physician: within 24 hours eller deeth. To the Funeral Director: After this cartifice completaly filled in by the funeral director.	Certification; To B	examiner? 1 Yes No 27. Manner of Death No Natural 5 Pending 2 Accident investigatie 3 Suicide 6 Could not	28a. Date of Inju (Month, Day	Year) Injury	M 28c.	Injury at Work? 1 DYes 2 D	28d. De	scribe how inju		ural Route Number,
DIVI	Hospital or A 14 hours efter (Funaral Dirac laly filled in by	edical Certifi	4 Homicide determine 29a. Certifier Check only 2 Medical Exe	building, etch hysician: To the best of miner: On the basis of	of my knowledge, deat examination and/or in	n occurred at t	the time, date and	City d place, and due	or Town, Stat	e) and manner a	s stated.
)	To the within 2 To the complet	Med	29b. Signature and title of certifier Plashart	Shible	2	000	icense number)		ate signed (Moni	th, Day, Year)
	Str. Regist	ate rar	30. Name and address of person who Prashaut Shuke, 31. Date filed (Month, Day, Year)	15 South P	eath (Item 23a) (Type, arke Street	# 400	Abeide	een MO	21001		

Dewon Sharp 04-3710 AKG Physic /Med Exan Funera Directo permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23s or 28a-f show any injury or other treumatic event, The Medical Exattrina Landellike Landellike Baltimore, Maryland 21215-0036 🍼 Physician /Medica

Examine

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the Innertal director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

		State of Maryland / Der		lental Hvoie	-	
		State of Maryland / Dep 1- State Unpend Item #23a,27,28a-£	ertificate of Beath 7/1		S NG A A I	00000
	ş <u>ş</u>	1. Decedent's Name (First, Middle, Last)) ,	2. Date of Death	Day Year	3. time of Death)
cia Iic		De'won Ontray 5	haRP, JR.		2004	7:49 A M
in	ęr	4a. Facility Name (If not institution, give street and number)	4b. City, Town/or Location of Death		4c. County of Dea	
i	7	Dorchester General Hospital 5. Social Security Number 6. Sex, 7. Age (In yrs. last birthday)	Cambridge y) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Dorchest	thplace (State or Foreign ountry)
r		217-90-3769 10M 20F Yrs.	Months Days Hours Min.	March 29		aryland
		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	Location		7	10d. Inside City Limits
	tor	MT Dorobesten Can	ahir doo.			1 Ø Yes 2 □ No
	irec	10e. Street and Number	10f. Zip Code	10g.	Citizen of What C	ountry?
	al D	704-MOURES AVE. APt.B	2/6/3		USA	2
	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto 	ecify Yes or No- Rican, etc.)	14. Race · Am Black, Whi	
	by F	1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: Q	ack
	Completed by	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	sedent's Usual Occupation	16t	o. Kind of Business	
	mple	Elementary/Secondary (0-12) College (1-4or 5+)	re kind of work done during most of work. DO NOT use retired)	Tig .	Non	0
		17. Father's Name (First, Middle, Last)	/VOIDE	e (First, Middle, Maid		
	To Be	De'won Ontray Sharp	Sp M: N'a	+aink	00	0000
	-		iling Address (Street and Number or Rura	al Route Number, Ci	ity or Town, State,	Zip Code)
		Nikia Taiwan Cooper 704 20a. Method of Disposition 20b. Place of Disp	Moores Ave. AP	1.B Camb	ridge, 1	1D. 21613
		20a. Method of Disposition 20b. Place of Disposition 1 ☑ Burial 2 □ Cremation 3 □ Removal from State	position (Name of ematory or other place)	Date 20c	. Location dity or	Town, State
		'4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service Licensee	(emetery 6//	2/04 Ca	Mbridge	MD, 21613
		Danolla Callena H	Yenry Funeral	Home, C. St. Canb	A. dae 1	10 21613
F		23a. Part / Exter the disease, or complications that caused the death. To not en shock or heart failure. List only one cause on each line.			riage	Approximate Interval Between
,		Immediate Cause (Final disease or condition Sudden Unexp	olained Death In	Infanc	У	Onset and Death
l r		resulting in death) Due to (or as a consequence of):				
ža,	er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
Ì	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events C.				
ŀ	Exa	resulting in death) Last Due to (or as a consequence of):				
	dical	d	-			
	by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of de	livery
	icla	in the past 12 months?	☐ Ectopic pregnancy ☐ Other (specify)		Month	Day Year
	Phys	9 U Unknown		00. 51444	1	
	d by	Part II. Dther significant conditions contributing to death but not resulting in the	underlying cause given in Part I.			the cause of death?
	Completed			24a. Was an		
	omo			autopsy performed	? death?	completion of cause of
	BeC	25. Was case referred to medical examiner?	26. Place of Death	1 Yes 2 ☐ 1 (Check only one)	No Takes	2 □ No
	٩	1XX es 2 No Hospital: 1 ☐ Inpatient 2 XER/Outpatie				cify)
	tlon:	27. Manner of Death 1 Natural 5 Pending F. Weith Per Year) 2 Accident investigation 6/3/0/1	of 28c. Injury at 10 Work?	28d. Describe how in	ljury occurred	
	ifica	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide Accident Investigation 6 / 3 / 04 7 · 1 / 4	A	Unknow 28f. Location (Street		ural Route Number Dores Ave.
	Certification:	Residence		ambridge		Jores Ave.
	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dea 2 Medical Exeminer: On the basis of examination and/or in and manner stated.	ath occurred at the time, date and place, a investigation, in my opinion, death occurred	and due to the cause ed at the time, date a	(s) and manner as and place, and due	s stated. to the cause(s)
	Σ	29b. Signature and title of certifier	29c. License number		Date signed (Mont	
		yulet -	O.C.M.E.	Jur	ne 4, 200	4
		30. Name and address of person who completed cause of death (Item 23a) (Type ANA RUBLO NO	111 Penn Street,	Raltimore	Man 1	-d 2220c
ta	te	31. Date filed (Month, Daj UN) 0 9 2002. Registar's Signature	1. N.	PATE THEORE	, rary la	шо 21201

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** SUNITHA SAMUEL 06 04 2004 5:50 A M /Medical 4c. County of Death 4a. Fecility Name (If not institution, co eet and number 4b. City, Town, or Location of Death **Examiner** TAKOMA PARK MONTGOMERY WASHINGTON ADVENTIST HOSPITAL If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 04/06/1980 9. Birthplace (State or Foreign Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 ☐ M 21 F 24 217-19-4284 MARYLAND Director Usual Residence of Decedent 10d. Inside City Limits

X
1 ☐ Yes 2 ☐ No the Maryland 10c. City, Town or Location 10a. State 10b. County or 28a-f show nunt be notified at TAKOMA PARK MONTGOMERY MD Director 10g. Citizen of What Country? 10e. Street and Number 10f Zip Code U.S.A. 20912 7801 WILDWOOD DRIVE "natural", or Items 23a death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 20 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours atter. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural any injury or other trees. 1 Never Married 2 Married Specify: INDIAN 1 Yes 2 No Baltimore, Maryland 21215-0036 Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) STUDENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be NIRMALA JACKSON PALKULAM J. SAMUEL ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7801 WILDWOOD DRIVE, TAKOMA PARK, MD 20912 PALKULAM J. SAMUEL - FATHER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a Method of Disposition 1 Burial 2 Cremation 3 Removal from State 06/06/2004 ADELPHI, MD George Washington * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME 21. Signature of Funeral Service Licensee DIC. 11800 New Hampshire Avenue, Silver Spring MD 209 4 wane 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition neumonia Physician resulting in death) /Medical Due to (or as a consequence of) Examiner nsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that inflated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): P.O. Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 pronths? Month Day Year jo 4☐Pregnant at time of death 5 Other (specify) page 2 should be detached 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2 No 1 ☐ Yes 2 No certificate 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation death. within 24 hours after deatl To the Funeral Director: completely tilled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 6/4/2004 52326 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
James K. Lightfoot, MD 7600 Carroll Ave. Takoma Park, MD 20912

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

JUN 0 8 2004

Docks

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene) 20038 For state State RegistrarAMEND#18perINF, 6/14/04, BMW, Mertificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** June 6, 2004 11:45A Roslyn R. Schaefer /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Potomac 10912 Lamplighter Ln If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Oay, Jan 5, 9. Birthplace (State or Foreign Country)
New York 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 X F Months Days Hours Min. 73 078-24-0285 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 28e-f show Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Health and Mental Hyglene.
and it if team 22 is marked other than "naturel", or items 23s or 28s-1 show and it is the properties of the propertie 1 ☐ Yes 2 No Directo Potomac Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20854 Funeral 10912 Lamplighter Ln 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Baltimore, Maryland 21215-0036 þ 3 ♥ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. OO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Education Teacher permit. Pages 1 and 2 should be filed w. Depertment of Health and Mental Hygien Importent: If Item 27 is marked other th any injury or other treumatic event, Its once. 4 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Anna Unobtainable 2 John Kahaner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10912 Lamplighter Ln, Potomac, MD 20854 Marc Schaefer/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Jun 8, 2004 Falls Church, VA 4 Donation 5 Other (Specify) King David Mem 22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 1 month Immediate Cause (Final Liver Failure Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** 10 years Metastatic Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transi Ovarian Cancer and that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year jó Day 4 Pregnant at time of death 5 Other (specify) been signed by the s should be detached o 9 Unknown ن 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? certificate 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: after death.

Director: After this certific d in by the funeral director. 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 3 DDA Medical Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27 Manner of Death Injury 1 XNatural 5 Pending 1 TYes 2 No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 - Homicide within 24 hours a 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier June 7, 2004 D0017368 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Center Park Dr, #200, Silver Spring, MD 20902 2101 Stanley A. Schwartz, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 1 0 2004 Registrar

			1 - For State of Maryland / De State of Maryl		ent of F				iene _{eg. N} 2. N () I.	200	20
	Physici		Decedent's Name (First, Middle, Last) Margaret Hatcher Shanle					2. Date of Dear Month June	th Day	Year	3. Time of 9:40	f Death
	/Medio Examin		4a. Facility Name (If not institution, give street and number) Mariner Health-Bethesda	4b.	City, Town, or Bethes	da			Mont		rv	
	Funeral Director		5. Social Security Number 264-26-2588 6. Sex 1 M 2 4 7. Age (In yrs. last birth 81 Yr. Usual Residence of Decedent	rs. If U	nder 1 Year oths Days	If Under Hours	Min.	3. Date of Birth (Month, Day, Oct. 3.	1, 1922	1 D D:+	nplace (State of untry) nnectio	
	e Maryland Sa-f ehow	Director	10a. State 10b. County 10c. City, Town Maryland Montgomery Potoma								10d. Inside C	ity Limits 2 X No
	ath with th	rai Dire	10410 Democracy Lane		Zip Code					S.A.		
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Ite Medical Examinating the notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:		ecedent of H specify Cuba es 2 X No	ispanic Or in, Mexica Specify:		ify Yes or No- ican, etc.)	Bla	ce - Amer ck, White by: Whi	•	
Baltimore, Maryland 21215-0036	within 72 ho iene. than "natui I'e Medical	Completed	(Specify only highest grade completed) (Give kind c	Usual Occup If work done of OT use retired	during mos	st of working	7	16b. Kind of B		ndustry	
/land 2	uld be filed Mental Hygi arked other atic event, j	To Be C	17. Father's Name (First, Middle, Last) William E. Hatcher		_			First, Middle, A	Maiden Suman			
e, Mary	and 2 sho lealth and I m 27 Is me		Lisa Shanley/ Daughter 10)4 1 0 I)emocra	and Number	ane,	Potomac	, MD 2	0854		
Itimore	it. Pages 1 Intment of H Intent: If ite njury or ot		20a. Method of Disposition 1 \(\frac{\text{N}}{2} \) Burial 2 \(\subseteq \text{Cremation} \) 3 \(\subseteq \text{Removal from State} \) 4 \(\subseteq \text{Donation} \) 5 \(\subseteq \text{Other} \((Specify) \) 21. Signature of Funeral Service Licensee	of He	or other plac aven y	1	20	2 12 ,	20c. Location - Silver	Spri	ing, Mai	rylan
Ba	perm Depa Impo any i		23a. Part1. Enter the disease, or complications that caused the death. Do no	50	00 Univ	versi	ty Bl	Funera vd., W,	Silve) 90001
	Pnysician /Medical		shock, or heart failure. List only and cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pneumonia Due to (or as a consequence of):							Onset and [Death
8760,	Examine be executed physicien and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs (Cisses) of if jury that initiated events resulting in death) Last b. Due to (or as a consequence of Due to (or as a consequenc					-				
.O. Box 68	death certific e attending p ed for use as	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Unknown Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown Unknown 1 Live birth 2 Fetal death 1 Live birth 2 Live birth 3 Live birth		ic pregnancy r (specify)					te of deliventh	_	Year
ecords, P.	sigr d be	ed by Pr	Part II. Dther significant conditions contributing to death but not resulting in t	he underlyi	ng cause give	en in Part I	i. 		acco use cont es 2 XNo		the cause of d	
Œ		Completed					_	24a. Was ar autops perforn 1 Yes 2	y ned?	Were auto prior to co death? 1 Yes	opsy findings a completion of ca	available ause of
Division of Vital	To the Hospital or Attanding Physician: Th within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, pag	Certification: To Be	2 Accident investigation 3 Suicide 6 Could nice be 28e, Place of Injury - At home, farm	ne of ury M		er: 4 🔀 Nu	ursing Home 28	Check onl one 5 ☐ Reside d. Describe ho f. Location (Str	nce 6 □Oth w injury occurr	red		ber
Ο̈́	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by		4 ☐ Homicide building, efc. (Specify) 29a. Certifier (Check only 2 ☐ Medical Examiner: On the basis of examination and/	death occu	rred at the tim	ne, date an	nd place, and	d due to the ca	iuse(s) and ma	inner as	stated.	
)	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29b. Signature and title of certifier Adam and manner stated. 30. Name and address of person who completed cause of death (Item 23a) (T	N.D.	29c. License		am occurred		ed. Date signed		Day, Year)	
	Sta Registr		Alpana Goswami, M.D. 11119 R 31. Date filed (Month, Day, Year) JUN 11 2004		lle Pi	ke, I	Rockvi	lle, M	D-20852	<u> </u>		

DHMH 17 Rev 1/2001

Registrar

JUN 0 9 2004

			State Registrer	te of Maryland / Depa			ntal Hygier	_	2001.1
}	Physici /Medio Examir	al	Decedent's Name (First, Middle, Last) Bernard Lee Swain, S 4a. Fecility Name (If not institution, give street a)		4b. City, Town, o		2. Date of Death Month June 7,	Day Year 2004 4c. County of Death	3. Time of Death
	Funeral Director	CI	Suburban Hospital 5. Social Security Number 234-28-9683 Usual Residence of Decedent	7. Age (In yrs. last birthday)	Bethesd If Under 1 Year Months Days	a If Under 24 Hrs. 8	Date of Birth	ont gomer	y place (State or Foreign
and 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "neturel", or items 23a or 28e-1 show eumatic event, the Medical Examinar must be redified at	o Be Completed by Funeral Director	10a. State 10b. County Maryland Montgomery 10e. Street and Number 4400 East-West Highwa: 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed)	S Decedent Ever in U.S. ed Forces? Yes 2 \sum No World as, Give or or Dates:War II 16a. Deced (Give) ege (1-4or 5+)	10f. Zip Code 20814 Vas Decedent of Ir Yes, specify Cub	pation during most of working d)	Unity Yes or Nocan, etc.) 16b. Re	Citizen of What Counted State 14. Race · Americ Black, White, Specify: White White Airport	es can Indian, etc.
Baltimore, Maryland	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injur or other treumatic as Once	To	19a. Informant's Name/Relationship (Type, Print Bernard Lee Swain, Jr 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal 1 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral/Service Vicensee	/ Son 1210 I	Nindrock sition (Name of atory or other place Wh Park Name and Addre thesda-C	Drive, McI Drive, McI Dat Dat June 14, ss of Facility Rober	Coute Number, City Lean, Vir 20c. 2004 Roc Ct A. Pum Inc. 75	ginia 221 Location - City or To kville, M phrey Fun 57 Wiscon	.02 own, State
760,	Medical / Medical Examiner	ical Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	that caused the death. Do not entered on each line. Lute Bleed with lue to (or as a consequence of): noracic Aneurism ortic Aneurism ue to (or as a consequence of): ortic Aneurism ue to (or as a consequence of): ronic Obstructiv	olood as	ng, such as cardiac or r	espiratory arrest,		Approximate Interval Between Onset and Death
P.O. Box 68	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	in the past 12 months?		Ectopic pregnancy Other (specify)	1		23d. Date of delive Month	ery Day Year
Records, F	ne law requires that has been signed b ge 2 should be det	Completed by P	Part II. Other significant conditions contributing Femoral Artery Occlut		derlying cause giv	en in Part I.	23e. Did tobacco	24b. Were auto	ably 4 Unknown psy findings available impletion of cause of
or Vital	iing Physicien: h. After this certifica funeral director, p	To Be	25. Was case referred to medical examiner? 1 🖾 Yes 2 🗀 No 27. Manner of Death 1 🛣 Natural 5 🗀 Pending investigation	1 Inpatient 2 ☐ ER/Outpatient Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injur Wor	4 Indising Home	1 ☐ Yes 2 € N Check only one)	1 ☐ Yes 6 ☐ Other (Specify	
Division	To the Hospitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the	ical Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e.	Place of Injury - At home, farm, stre building, etc. (Specify) To the best of my knowledge, death the basis of examination and/or invited the basis of examination an	occurred at the tir	ne, date and place, and	City or Town, Sta	s) and manner as si	ated.
L	To the P	Medical	29b. Signature and title of certifier	manner stated.	29c. Licens D2051	e number	29d. D	ate signed (Month,	
		Ø 21	30. Name and address of person who completed Joe 1 R. Schulman, M.D. 31. Date filod (Month, Day, Year) JUN 0 8 2004	5480 Wisconsin	•		y Chase,	Maryland	20815

			1 For State	State of Ma		partment of Health and I	Mental Hygie	ne	
			Registrar 1. Decedent's Name (First, Midd	le (e et)	Ce	ertificate of Death		No.2004	2001.2
	Physici		Ildra	e, Last) Rosal	lie	Twigg	2. Date of Death Month MAY 28	Day Year	17:00 M
	/Medic Examir		4a. Facility Name (If not institution			4b. City, Town, or Location of Deatl		4c. County of Death	
			MEMORIAL HOSPI	TAL		CUMBERLAND		ALLEGANY	
	Funeral		5. Social Security Number		(In yrs. last birthday	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye 01/26/19	9. Birth	place (State or Foreign intry)
5	Director		214-07-4768 Usual Residence of Decedent		38 Yrs.		01/26/19	16 Mary	land
	yland		10a. State 10b. County		10c. City, Town or I	ocation			10d. Inside City Limits
	e Mar	ctor	MD A1	legany	LaVa	Le			1 ☐ Yes 2 No
	th with th	al Director	10e. Street and Number 55 LaVale B	oulevard		10f. Zip Code 21502	10g.	Citizen of What Cou USA	intry?
036	s within 72 hours after death with the Maryland liene. r than "natural", or Itema 23a or 28e-1 show The Medical Exarinet must be rotified at	by Funeral	11. Marital Status 1 Never Married 2 Mar 3 XWidowed 4 Divorced	If Yes Give		Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 ☒No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White Specify: Wh	
Q 2	72 ho	ted		it's Education st grade completed)	16a. Dec	edent's Usual Occupation e kind of work done during most of wor	ting 16b	. Kind of Business/I	ndustry
Maryland 21215-0036	within iene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+) life.	omemaker		Homemaker	
2	be filed ntal Hygie od other	Be C	17. Father's Name (First, Middle,				ne (First, Middle, Maio	_	1
<u>₹</u>	should be and Mental marked o	ဥ	Earl	Gaur		Ildra			ynch
	ss 1 and 2 should of Health and Men Item 27 is marker other traumatic		Jane E. Barnes		5.5	ling Address <i>(Street and Number or Ru</i> LaVale Boulevard,			21502
Baltimore,	w = -		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal from State	20b. Place of Disp cemetery, cri	position (Name of ematory or other place)	Date 20c	. Location - City or T	own, State
Ē	L. Pages tment of tant; if it tjury or o		`4 □Donation 5 □Other (S	Specify)		st Mem. Park 06/0		Cumberland	
Ba	permit. Page Department of Important: If sny injury or		21. Signature of Funeral Service	Acles 1	1	22. Name and Address of Facility Ad 404 Decatur Stree	,		21502
В				complications that raused only one cause on each line	the death. Do not ea e.	nter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	ration Pne	eumonia			< 1 week
	Examiner		,		re COPD				>5 years
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	D	consequence of):) years
	cuted nd ransit	Examiner	that initiated events	с.					
68760,	icate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a	consequence of):				
		fedical		0.					
.O. Box	he death certifi the attending t thed for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at 1 9 □ Unknown	2 ☐ Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of deliving Month	ery Day Year
<u> </u>	requires that the de been signed by the a hould be detached t	by	Part II. Other significant conditi	ons contributing to death bu	t not resulting in the	underlying cause given in Part I.	. ^	co use contribute to t	he cause of death?
I Records,	The law ate has b page 2 s	Completed					24a. Was an autopsy performed	prior to co	opsy findings available impletion of cause of
Vital	Physician: The this certificate ral director, pages	Be	25. Was case referred to medica examiner?				th Check on one		
ō	S Si	1. 70	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatier 28a. Date of Injury			ome 5 Residence 28d. Describe how in		(y)
on	Attanding ir death. ector: After by the fune	tlon	1 Natural 5 Pendi 2 Accident invest	ng (Month, Day	Year) Injury	Work? M 1 ☐ Yes 2 ☐ No	Log. Dogottoo now ii	ijary occurred	
Division	if or Attandi after death. Director: A d in by the fu	Certification;	3 Suicide 6 Could 4 Homicide determ		ry - At home, farm, s . (Specify)	treet, factory, office	28f. Location (Street City or Town, St		al Route Number,
_	Hospita 4 hours Funeral ely filled	edical Co	29a. Certifier 1 Certifyi (Check only one) 2 Medical	ng Physician: To the best of Examiner: On the basis of and manner state	examination and/or i	th occurred at the time, date and place, nvestigation, in my opinion, death occur	and due to the cause red at the time, date a	e(s) and manner as s and place, and due to	tated. o the cause(s)
	To the To the To the Complet	Med	29b. Signatur and title of certifie			29c. License number	29d. l	Date signed (Month,	Day, Year)
)	2		MANN	VIIIAA A	1	D16041	1	une 1, 20	04
			30. e and address of person	who completed cause of de	eath (Item 23a) (Type			<u> </u>	V 7
1	カムリ			RY E., M.D.,	500 MEMOR	IAL AVENUE, CUMBER	LAND, MD 2	21502	
	Sta Registr		31. Date filed (Month, Day, Year, JUN 0 1 2)04 Registral	r's Signature	Spark			

State of Maryland / Department of Health and Mental Hygiene

					Oldic Of	viai yiai	•	tificate of	Death		Reg. No.	0.1	
			1. Decedent's Name (First,	Middle, Le	st)	•				2. Dete of De	eth 2	04	3. Time of Death
	Physici		THOMAS	TA	1RR					Month	13, 200	Year 14	2:40 a.m.
	/Medio Examir		4a Facility Name (If not ins		1,00	er)			4b. City, Town, or	Location of Death			2.40 a.m.
d	E Aditiii	eı	2162 Shei	_		•			Harres	de Grace	1		1
	F		5. Social Security Number	6. S		Age (In vrs	last birthday)	If Under 1 Yea				rford	
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	puel m		10a. Stete 10b. C			10c. Cit	ty, Town or Loc	ation				10	d. Inside City Limits
	Sa-f sh	ctor	1115	rfor	Ē.	H	avre de	,					1 ☐ Yes 2 XX ¶o
	th with the	Funeral Director	10e. Street and Number 2162 She	rwood	d Lane			10f. Zip Code	078		10g. Citizen of V		γ?
21215-0020	permit. Peges 1 end 2 should be filed within 72 hours efter death with the Merylend Depertment of Heelth and Mentel Hygiene. important: If item 27 is marked other than "netural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fune	11. Marital Status 1 Never Married 2 3 Dividowed 4 Div	-	12. Was Decede Armed Force 1 Types 2 If Yes, Give Year or Date	es? □ No	1	Vas Decedent of Yes, specify Cu ☐ Yes 2 🛣 No	Hispanic Origin? (S ban, Mexican, Puer Specify:	Specify Yes or No- rto Rican, etc.)	14. Rac Blac Specify	e - America ck, White, e : Whi	tc.
5-0	72 hc	ğ	15. Dec	edent's Ed	ducation de completed)		16e. Decede	ent's Usual Occi	upation a during most of wo	rking	16b. Kind of Bu	siness/Inde	ustry
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21	gien g	Ķ	12		2	,	Purch	asing D	irector		Purc	hasin	a
b	of Hy	Be (17. Father's Name (First, M.	iddle, Last)					18. Mother's Na	me (First, Middle,	Maiden Sumam	Θ)	
Maryland	uld b Went	To T	Christophe	er Wes	st Tabb				Ella	Mae Dung	hy		
and a	s me		19a. Informant's Name/Rel	ationship (Type, Print)		19b. Mailing	Address (Stree	et and Number or R	urel Route Numbe	r, City or Town,	State, Zip (Code)
	end and and and and and and and and and a		Nancy Tabb (Wife)			212	6 Sherw	ood Lane	Havre	de Gra	ce, M	D 21078
Baltimore,	of He		20a. Method of Disposition 1 ☐ Burial 2 ☑ Crema	tion of	Damental from Sta	20b. F	Place of Dispos	ition (Name of etory or other pl	ace)	Date	20c. Location -	City or Tow	m, State
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alti	mit.		21. Signa ure of Funeral Se	rvice Licen	see				ess of Facility F				
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		\dashv	23a. Part1. Enter the disea shock, or heart failure	se, of comp	olications that caus	sed the deatl	h. Do not enter	r the mode of dy	arke St.	c or respiratory ar	rest.		Approximate
1	Physician		shock, or heart failure	List bely	one cause on eacl	n line.						1	Interval Between Onset and Death
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	Examiner		diseese or condition resulting in death)		a. ACO		or as a consequ		s Levi	COIT	7		3 14 104 (1 10)
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•	tificete be executed ng physician end es the buriel-transit	Ē	Sequentially list conditions		b		r as e consequ		1101011	\			
ó	an er riel-t	Ë	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			·		,				1	
68760,	ysici ne bu	Cal	that initiated events	5	C	Due to (or	r as a conseque	ence of):					
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Box	h cer endir use	2			d								
	deet e ett	흜	Part II. Other significant co	nditions co	ontributing to death	but not resu	ulting in the und	deriving cause o	iven in Part I.	23b. Did to	obacco use con	tribute to t	the cause of death?
P.0	es thet the deeth cel igned by the ettendir be deteched for use	Physician/Medicai Examiner						, ,			es 2 No	3 Proba	1
	gned be de	by											
of Vital Records,	requir been s should	Completed								24a. Was a perfor	in autopsy med?	avail	e autopsy findings lable prior to pletion of cause eath?
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ta			25. Was case referred to me	edical					26 Place of De	ath (Check only or			103 250.00
>	2 0 10	o Be	examiner? 1 ☐ Yes 2 No	-	Hospital: 1 ☐ Inpa	tient 2□	ER/Outpatient	3□ DOA O	her:	dome 5 Resid		r (Speciful	
0	ttending Phy deeth. :tor: After thi r the funeral		27. Manner of Death		28a. Date of In (Month, I		28b. Time of	28c. Inju		28d. Describe h			
<u>ō</u>	Attending is deeth. actor: After by the fune	읉		ending vestigation		Jay rear)	Injury		Yes 2 No				
Division	i or Attendi efter deeth. Director: A d in by the f	Certification:		ould not be etermined	28e. Place of	Injury - At ho etc. (Specif)		et, factory, office		28f. Location (S City or Tow	treet and Numbern, State)	er or Rural I	Route Number,
	To the Hospital or Atte within 24 hours efter de To the Funeral Directo completely filled in by the	Sel	29a. Certifier	tifying Phy	sician: To the be	st of my know	wledge, death o	occurred et the t	me, date end place	and due to the c	ause(s) and ma	ner as stat	led.
	in 24 in 24 in Fu	edicai	(Check only 2 Med	ncal Exam	Iner: On the basis end manner	of examinat stated.	tion and/or inve	stigation, in my	opinion, death occu	urred et the time, o	ate and place, a	nd due to the	ne cause(s)
	vithi Tott	ž	29b. Signature and title of ce	ertifier	0	1 4	0		se number	2	9d. Date signed		
	L 1		Naw	2 (of of	, M. J	D .	DOC	57450		06,14	,200	14
	15+1	-	30. Name end address of pe	rson who d	completed cause o	f death (Item	23e) (Type, Pi	rint)			22 81171	GAR ET	NE CHIEF
	1		WANA GOO, 1	DINE	RSITY OF	MARYU	AND GRE	EENEBA	UH CANCET	CENTER,	BAUNKO	W.	THE STREET
	Sta Registra	_	31. Date filed (Month, Day, JUN	(ear) 5	2004 32. Re	strar's Signat	ture A	book					

Physic		1 - For Registrar 1. Decedent's Name (First, Middle, Last)	State of Maryland		artment of H rtificate of L		2. Date of Death Month	n Day Year	2 0 0 4 4 3. Time of Death
Physici /Medi Examir	ical	4a. Facility Name (If not institution, give str				or Location of Death	June 9	4c. County of Dea	ath 0:30PM
Funeral Director		Usual Residence of Decedent	7. Age (In yrs. las	Yrs.	Waldo If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth	Charle 9. Bir	inhplace (State Dereign Washinton
ith the Maryland or 28e-f show	rector	10a. State 10b. County MD Char I		Wald			10	ng. Citizen of What Co	10d. Inside City Limits 1 Yes X No
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28e-f show sny injury or other traumatic event. If a Medical Examinating the nutified at once.	by Funeral Director	2831 Portobello	Ct. 2. Was Decedent Ever in U.S. Armed Forces? 1	1	2	20603 Hispanic Origin? (Span, Mexican, Puerto Specity:		USA 14. Race - Ame Black, Whit	nerican Indian,
nin 72 hour 3. an "natural Medical E	Completed b	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	ation	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	during most of work.	cing 16	16b. Kind of Business	/Industry
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nd 2 should be file alth and Mental Hy 27 Is marked oth r traumatic event	7	19a. Informant's Name/Relationship (Types David Temple/Hus	e, Print)			and Number or Run	ral Route Number, (City or Town, State, 2	
Physician /Medical Examiner		1 M Burial 2 Cremation 3 Ref. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, is any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	M0094	Do not ente	AREHART P.O. BO	E-ECHOLS	FUNERAL A PLATA	L HOME,P	Maryland A.A. Approximate Interval Between Onset and Ceath
requires that the death certificate been signed by the attending phys should be detached for use as the	by Physiclan/Medical	d.	ic. If yes, outcome of pregnanc 1 Live birth 2 Fetal de 4 Pregnant at time of deat 9 Unknown	cy death 3 ath 5	□Ectopic pregnancy □ Other (specify) underlying cause give		23e. Did toba 1 ☐ Yes 24a. Was an	s 2 No 3 □ Pr	Day Year to the cause of death? Probably 4 Unknown
an: The law rtificate has l tor, page 2 s	te Completed	25. Was case referred to medical				26. Place of Dea	autopsy performe	prior to death? No 1 □ Yes	completion of cause of
To tha Hospitel or Attanding Physician: The l within 24 hours after death. To tha Funaral Diractor: After this certificate ha completely filled in by the funeral director, page	Certification; To B	examiner?		R/Outpatien 28b. Time of Injury	of 28c. Injury Work M 1 🗆 Y	ner: 4 □ Nursing Ho ry at rk? Yes 2 □ No	ome Residence 28d. Describe how	nce 6 Other (Spewinjury occurred	
Hospitel 4 hours a Funaral i tely filled	Medical Co		ician: To the best of my knowle er: On the basis of examination and manner stated.			opinion, death occur	rred at the time, date		e to the cause(s)
o tha H ithin 24 o tha F omplete		200. 019	¥ .1	,	1	1.1.4.5	1		
To the H within 24 To the F complete		30. Name and address of person who com	pleted cause of death (Item 2	3a) (Type,	Print)	44431	0 1	um 09	2004 MD 20602

Thomas, Margaret Baltimore. Maryland 21215-0036

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State Part State	LAC		Ĭ.	Berlin Nursing and Re	hab.	Cente	er						
Description of Tendedon Tools City Units Tool				5. Social Security Number 6. Sex	7. Age	e (In yrs. las	it birthday)			(Month, Da	y, Year)		
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2 Accident 3 Suicide 4 Homicide 2 See. Plan of Injury: At home, farm, street, factory, office 2 See. Plan of Injury: At home	e P P	neral		27. Manner of Death 28a.				f 28c. In	ury at				
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296. Signature street certifiers D28769 6/11/04 10. Tame and address of person who completed cause of death (Item 23a) (Type, Print) 1209 Coxxtal Heyhway NIMola, N. Boradilla, M. Ferwick Folcol, De 19944	e Hospita 24 hours e Funera	letely fille		(Check only 2 Medicel Examiner: On	the basis o	f examination							
	To th Within To th	сошр		29b. Signature and tillic of certifier	his	6	2	29c. Lice	nse number 2 876 9		29d. Date	signed (Mon	oth, Day, Year)
	Ne.Ll			11:11 (2.	1 1.		23a) (Type,	Print)	09 Co	ustal slow	Heyl	nway	19944
	DO T			0.00100	- 2	-	ire		(CT) -T		~ (80	

			For State Registrar	State of Maryla		artment of I		Mental Hygie	0001	20046
			Decedent's Name (First, Middle, L.	_ast)				2. Date of Death	Day Year	3. Time of Death
	Physici /Medic	_	Diane H. Torell					June 8,	2004	12:25 A M
	Examin	er	4a. Fecility Name (If not institution, g				or Location of Dea	th	4c. County of Death	
455	Funeral			. Sex 7. Age (In yr	s. last birthday)				Cecil 9. Birth	place (State or Foreign
ings.	Director		193-38-6364	1□M 2以F	47 Yrs.	Months Days	Hours Min	September	20,1956	PA PA
	land ow		Usuel Residence of Decedent 10a. State 10b. County	10c. (City, Town or L	ocation				10d. Inside City Limits
	Mary a-f sh	tor	MD Cecil		Perryva	ille				1 ☐ Yes 2 X No
	or 28	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Cou	ntry?
	s 23e	rai	188 Chestnut Po	int Road 12. Was Decedent Ever in	11.5	21903	lii O-ii2 //		USA 14. Race - Ameri	een Indies
· O	fter de	Funerai	11. Marital Status 1 ☐ Never Married	Armed Forces? 1 □ Yes 2 X No	0.3.	Was Decedent of I	an, Mexican, Puei	to Rican, etc.)	Black, White	
21215-0036	be filed within 72 hours after death with the Maryland tal Hyglene. Id other than "natural", or items 23a or 28a-f show event, the Medical Estariline matal Le indiffied al	Ď	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify: (W	iite
5	n 72 h "natu	Completed	15. Decedent's (Specify only highest of		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wo	orking 16b	. Kind of Business/Ir	ndustry
77	iene.	ошр	Elementary/Secondary (0-12)	College (1-4or 5+) 5		istered			Nursina	
<u> </u>	be filed ital Hyg od other	Be C	17. Father's Name (First, Middle, La.	st)	, ,,,,,	, co co coa		me (First, Middle, Maid		
ya	should be filed within of Mental Hygiene. The marked other than matte event, the Mentalle was the matter event.	Lo L	Joseph Hite					y Hamilton		
Maryland	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 is marke any injury or other traumatic once.		19a. Informant's Name/Relationship Richard T. Tore.					ural Route Number, Ci		
	s 1 an f Heal itam 2 other		20a. Method of Disposition	20b.	. Place of Dispe	osition (Name of		Road, Personal Posts 200	Location - City or T	own, State
altimore,	Pages nent of int: If it iry or o		1 ☐ Burial 2X Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	□Removal from State cify) R.	T. Foar	d Funera	l Home.	89-04 Ri.	sina Sun-	Maruland
a	epartri porta ny inju		21. Signature of Fune al Servio.		2	2. Name and Addre	ess of Facility R.	T. Foard F	uneral Hoi	ne. P.A.
8	8 6 E E O		11			111 2. 8	ueen Str	eet, Kisin	g Sun, MD	21911
			23a Part1. Enter the disease, or co shock, heart failure. List on Immediate Cause (Final	by one cause on each line.	atn. Do not en	ter the mode of dyl	1		CIA	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a conse	equence of);	Soar	100	jaria	404	5/15
	Examiner		Sequentially list conditions,	b						
0	be tis	ılner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	equence of):					
1	be executed sicien and burial-transit	Examiner	that initiated events resulting in death) Last	c	equence of):					
760,	w - w	cai E		d						
89			IF FEMALE:							
Вох	death certifica e attending ph d for use as th	lan/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe	etel death 3[Ectopic pregnanc	у		23d. Date of deliv Month	ery Day Year
o.	0 0	Physician/Med	1 Yes 2 No	4□Pregnant at time of 9□Unknown	rdeath 5	Other (specify)				,
٥.	requires that the de neen signed by the a hould be detached f	by Ph	Part II. Other significant conditions	contributing to death but not re	esulting in the u	inderlying cause giv	ven in Part I.	23e. Did tobacc	o use contribute to t	he cause of death?
Records,	w require been sig should b							1 🗆 Yes	2 Prol	pably 4 Unknown
ec C	₹ 0 8	Completed						24a. Was an autopsy	prior to co	ppsy findings available impletion of cause of
								performed	death? 1 ☐ Yes	2□ No
Vita	Physician: this certificatal director.	o Be	25. Was case referred to medical examiner? 1 Yes 2	Hospital: 1 Inpatient 2	☐ ER/Outpatie	nt 3 DOA Ott	000	ath <i>(Check only one)</i> Home Desidence	6 DOther (Special	
0	ding Phy h. After this funeral o	⊢ 4	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	-	ry at	28 Describe how in		y)
Siol	Attending in death.	catic	Natural 5 Pending investigat 3 Suicide 6 Could not	ion	,,		Yes 2 □ No			
Division of		Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		home, farm, st cify)	reet, factory, office		28f. Location (Street City or Town, St		al Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir. completely filled in I	edical (29a. Certifier 1 Certifying I (Check only one)	Physician: To the best of my ki aminer: On the basis of examinand manner stated.	powledge, deat nation and/or in	h occurred at the til vestigation, in my o	me, date and place opinion, death occ	a, and due to the cause urred at the time, date	o(s) and manner as s and place, and due to	tated. o the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of centrier	1//////		29c. Licens	se number	29d.	Date signed (Month,	Day, Year)
)				1/1/11		1111	10007	660 to (18/0	41 11
	10		30. Name and address of person wh	o completed cause of death (Ite	em 23a) (790e	Printy 55	NH	4 CX	GVAN	d HX
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature		1000	() (C POC.	3
	Registr		JUN 9 200		AP ARTON	. 600				

			For State	State of	f Maryland		artment of I <i>rtificate of</i>			lentai Hyg	jiene		
	\$		Registrar 1. Decedent's Name (First, Middle,	Last)			rancate or	Deali		2. Date of Dea	th (104	3. Time of Death
	Physic /Medi		WAYMON GLEN	N THOMPSO	N					June	9. 70	O 4	07:04 A M
2.	Examir		4a. Fecility Name (If not institution,	give street and nun	nber)		4b. City, Town, o	or Location	of Death	0000	_	unty of Deet	h
			UNION HOSPITA				ELKTON					CIL	
	Funeral Director		221-40-9795	6. Sex 1 X M 2□ F	7. Age (In yrs. Ia 49	st birthday) Yrs.	Months Days	If Under Hours	r 24 Hrs. Min.	8. Date of Birth (Month, Day OCTOBER			hplace (State or Foreign untry) MICHIGAN
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	ocation	***					10d. Inside City Limits
	Maryl fet	ō	MARYLAND CECIL										1 ☐ Yes 2 No
	ath with the Marylan s 23e or 28e-f ehow wat be notified at	Director	MARYLAND CECIL 10e. Street and Number		<u>EI</u>	KTON	10f. Zip Code			1	0g. Citizen	of What Co	untry?
	th with	a D	213 RHETT LAND	E			2192	1			UNITE	D STA	TES
	or Items	Funeral	11. Marital Status	12. Was Dece Armed For	dent Ever in U.S	. 13.	Was Decedent of H	lispanic Or	rigin? (Spe	ecify Yes or No-		Race - Ame Black, White	rican Indian,
36	s afte	by Fu	1 Never Married 2 Marrie	If Yes, Giv	θ		1 ☐ Yes 2 X No				1	ecity: WHI	
21215-0036	d within 72 hours after death with the Maryland yiene. I'r than "natural", or Items 23a or 28a-f ehow I're Medical Exertire Franst be notitied at		3 ☐ Widowed 4 ☐ Divorced 15. Decedent*	Year or Da	ites:	16a Dacar	dent's Usual Occup	aation					
15	n "na	Completed	(Specify only highest	grade completed)		(Give	kind of work done DO NOT use retire	during mos	st of worki	ing	16b. Kind c	f Business/I	ndustry
212	d within giene. or than "	mo	Elementary/Secondary (0-12)	College (1	-4or 5+)	CONT	RACTOR				CONS	TRUCT	ION
ng	be filed tal Hygi d other	Bec	17. Father's Name (First, Middle, L	ast)				18. Moth	er's Name	(First, Middle, I			
ylaı	should by nd Menta marked	To	GENERAL WAYMO	N THOMPSOI	N			MAR	GIE J	JONES			
Maryland	s 1 and 2 should be filed f Health and Mental Hyg Item 27 ie marked othe other traumetic evant.		19a. Informant's Name/Relationsh	-			ng Address (Street					wn, State, Z	ip Code)
	s 1 and 2 if Health a ltem 27 le othar trae		DONNA THOMPSON	/WIFE	20h Pia		RHETT LA	NE, E					
altimore,	Pages nent of H int: If Its iry or of		20a. Method of Disposition 1 Description 2 Cremation		cer	netery, crer	matory or other place The State of the place The Sta	ce)				on · City or 1	own, State UN MD
Ħ	구두다른		* 4 □ Donation 5 □ Other (Sp. 21. Signature 1 Service L		1		2. Name and Addre						
Ba	permi Depa Impo any ir		1 Auch (Mis			1 SOUTH						
4	1. 13.		23a. Part 1. Enter the disease, or o	omplications that ca	used the death.			•			-		Approximate
	Physician		shock, or heart failure. List o				1.17	1 7	ζ1 ₆				Interval Between Onset and Death
	/Médical		disease or condition resulting in death)		or as a conseque		idial In	parci	100				Immediate
П	Examiner		Sequentially list conditions	b. ———									
0	D 5	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or highry		or as a conseque	nce of):							
1	licate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to /c	or as a conseque	man of							
60,	be ex ician buria			D00 (0 (0	n as a conseque	ince or).							
68760,	licate phys s the	edical	- `	d									
Box (certif nding use a		IF FEMALE: 23b. Was decedent pregnant		ome of pregnanc						234	Date of deliv	100/
ğ	death s atter d for u	Physician/M	in the past 12 months?		nth 2 ☐ Fetald ant at time of dea		Ectopic pregnancy Other (specify)	1				Month	Day Year
P.O.	t the by the	hys	9 Unknown	9□ Unkno	wn								
	law requires that the death certif as been signed by the attending 2 should be detached for use a:	ру Р	Part II. Other significant condition	1 /				en in Part I.		23e. Did tob	acco use co	ontribute to	the cause of death?
ord	w require been signature	ted	ASCUU, P	erip heral	Va you	lard	; sease			1 ☐ Ye	s 2□No	3 ☐ Pro	bably 4 Unknown
ec	has be	Completed	Hypertengio.							24a. Was ar	24	b. Were auto	opsy findings available ompletion of cause of
₩ ₩	Tr Tr	Son	/ *							perform	ed? X No	death? 1 🗆 Yes	
Division of Vital Records,	iician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hamital			Tou		of Death	(Check only one)		
ot	Phys this ral dir	<u>۲</u>	1 🖟 Yes 2 □ No 27. Manner of Death	Hospital: 1 🗆 In		VOutpatien 8b. Time of		4 🗆 140		ne 5 Reside			fy)
on	ding h. After	tou	1 Anatural 5 Pending 2 Accident investiga	(Month	Day Year)	Injury	28c. Injun Worl	yal k? Yes 2 ⊟1		8d. Describe ho	w injury occ	urred	
/isi	Atter r deal sctor	ifica	3 Suicide 6 Could no	t be	of Injury - At hom	e, farm, stre	set, factory, office		-	8f. Location (Str	eet and Nu	mber or Run	al Route Number,
ā	s afte	Certification:	4 Homicide determin	buildin	g, etc. (Specify)		,			City or Town	State)		
	ospit hours unara ly fille	cal (29a. Certifier 1 ☐ Certifying (Check only 2 M Medical E	Physicien: To the I	pest of my knowle	edge, death	occurred at the tim	ne, date an	d place, a	nd due to the ca	use(s) and	manner as s	stated.
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funaral Director: After this certificate his completely filled in by the funeral director, page	fedical		caminer: On the bas and manne	sis of examinations of stated.	n and/or inv			th occurre	at the time, da	te and plac	e, and due t	o the cause(s)
	with To	Σ	29b. Signature and title of certifier	/,			29c. License	nedmun e				ned (Month,	
•			I far	(as, M))		115	3 14	1	.7	une	1,200	74
	3		30. Name and address of person w	1 / F	71 . /	4	1 4						
	Sta	to	If FurlLas, My 31. Date filed (Month, Day, Year)	32. Re	gistrar's Signatur	1	Klon, MD						
	Sta		111N 1 4 200/	Flores.	15	Shows all							

			for State	State	of Maryla				d Mental Hy	giene	
			1 - State Registrar 1. Decedent's Name (First, Middle, L	4)		Ce	rtificate of l	Death		Reg. No.	14 20048
Н	Physic	an		•					2. Date of Dea Month	Day	3. Time of Death
	/Medi			is June		yer Tay				e 8, 20	
	Examir	ner	4a. Facility Name (If not institution, g.				4b. City, Town, or			4c. County	of Death
	Funanal		Montgomery Ho 5. Social Security Number 6.	spice Ca		use . last birthday)		ockvill		M	ontgomery
	Funeral Director		528-26-6613	1□M 2🕅 F	78	Yrs.	Months Days		lin. (Month, Da)		Birthplace (State or Foreign Country)
	ъ		Usual Residence of Decedent		76				June 1	, 1920	Utah
	nylan how		10a. State 10b. County		10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	B Ma	ç	Maryland Mont	gomery			F	Sethesd	а		1 ☐ Yes 2 🎇 No
	ith th or 28	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of V	What Country?
	ath w		5009 Sen	tinel D	rive #5	5		20816		Un	ited States
	er deg	Funerai	11. Marital Status	Armed F		J.S. 13.	Was Decedent of Hi f Yes, specify Cuba	spanic Origin?	(Specify Yes or No- uerto Rican, etc.)	14. Rac	ce - American Indian, ck, White, etc.
36	s afte	by Fi	1 Never Married 2 Married	1 ☐ Yes If Yes, Gi	ve -		1 ☐ Yes 2 🛣 No	Specify:	, ,	Specify	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. tther than "natural", or Items 23a or 28a-f ahow ont, the Medical Examinar must be recitified at	pe pe	3 Widowed 4 Divorced	Year or D	ates:	100 David	1-1-1-10				White
Ϋ́	in 72	Completed	15. Decedent's E (Specify only highest g	rade completed)		(Give	ient's Usual Occupa kind of work done o DO NOT use retired	during most of	working	16b. Kind of Bu	usiness/Industry
72	with iene.	mo	Elementary/Secondary (0-12)	College (1-4or 5+)		Congression		a	II C	Carrommont
0	Hyg other ent,	BeC	17. Father's Name (First, Middle, Las				Oligiessi		Name (First, Middle,		. Government
<u>a</u>	lid be lental ked ic ev	To B	R	aymond V	Jhitmax	0 °			_		
Maryland	2 should be f and Mental b Is marked ot raumatic ever	-	19a. Informant's Name/Relationship		VIII CINC Y		g Address (Street a	and Number or	Rural Route Number	aye Kinş r, City or Town,	
	alth alth a		Sarah Wightman Tay	lor/ Da	ughter						vland 20814
altimore,	of He of He item		20a. Method of Disposition	-	20b.	Place of Dispo	sition (Name of natory or other place				City or Town, State
Ĕ	Pages nent of P ant: If it		1 ☐ Burial 2 X Cremation 3 (State MO	ntgomer	um Inc.	1	e 9,2004	Rethes	sda, Maryland
a	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28s-1 ahow any injury of other traumatic event, the Medical Eventiner must be prefitted at once.		21. Signature of Funeral Service Lice	ensee		22	. Name and Addres	s of Facility R	obert A	Pumphra	W Funoral Home
<u>m</u>	89 = 99	(0.1)	1 Cauc	X-EN	→ M013	86 Be	thesda, N	ievy Ch Marylan	ase 1nc d 20814-35	7557 W: 501	isconsin Avenue
В			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that of	caused the dea	th. Do not ent	er the mode of dying	, such as card	liac or respiratory arr	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Lung	Cancer						Onset and Death 8 Months
	/Medical Examiner		resulting in death)	- u	(or as a consec	quence of):					o Honens
	Lammer	_	Sequentially list conditions.	b							
	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consec	quence of):					
_	and and I-tran	Examiner	that initiated events resulting in death) Last	c. Due to	(or as a consec	Tuence of):					
9	icate be executed physician and s the burial-transit			540 (0	(01 40 4 0011000	quonce on.					
98760	The law requires that the death centificate be executed to has been signed by the attending physician and age 2 should be detached for use as the burial-transit	edical		d							
XOA	eath certifi attending for use as		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregn.	ancy		-		22d Date	e of delivery
	death s atter	Physician/M	in the past 12 months?		oirth 2 Feta lant at time of c		Ectopic pregnancy Other (specify)			Mon	.,
J.	at the de by the a tached	hysi	9 Unknown	9□ Unkn	own						
	res that igned b	by P	Part II. Other significant conditions	contributing to de	eath but not res	sulting in the un	derlying cause give	n in Part I.	23e. Did tob	acco use contri	ibute to the cause of death?
ğ	w require been sig should b								1 🗆 Ye	s 2 No	3K Probably 4 □Unknown
Vital Hecords,	aw re s bee	Completed							24a. Was a	n 24b. W	Vere autopsy findings available
ĭ	sician: The law certificate has t irector, page 2 s	mo							autops perform	y pr ned? de	rior to completion of cause of eath?
<u>g</u>	ian: rtifica	e ·	25. Was case referred to medical					26 Place of F	1 ☐ Yes 2 leath (Check only only		☐ Yes 2☐ No
OT <	Physic this ce al direc	To B	examiner? 1 □ Yes 2 🔀 No	Hospital: 1 🔲 I	npatient 2	ER/Outpatient	3☐ DOA Othe		100000000000000000000000000000000000000		er (Specify) Hospice
0	ding Ph h. After th funeral		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date	of Injury th, Day Year)	28b. Time of Injury	28c. Injury Work	at	28d. Describe ho		
DIVISION	tendir death. tor: Al the fu	atic	2 Accident investigation	n	, = 5, ,	,ury		es 2 □ No			
Ĕ	I or Attending Physician: after death. Director: After this certifica i in by the funeral director,	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	286. Place	of Injury - At h	ome, farm, stre	et, factory, office		28f. Location (Str City or Town	reet and Numbe. . State)	er or Rumi Route Number,
_	oital (urs al ural D								U.		
	Hosp 4 hou Fune Fune	edicai	Medical Exa	miner: On the ba	asis of examina	wledge, death	occurred at the time	e, date and pla	ce, and due to the ca	use(s) and man	nner as stated. nd due to the cause(s)
	To the Hospital or Atte within 24 hours after de To the Funeral Direct completely filled in by th	Med	29b. Signature and title of certiler	and man	ner stated.						
		-	250. Signature and three process left	1	Mn		29c. License		29	a. Date signed	(Month, Day, Year)
)	10		, -LM	/-	ب			D35635		Jun	ne 8, 2004
				com ed caus			•	. 1	34 1	1 000=	
	Sta	0	Joseph Kaplan, M. 31. Date filed (Month, Day, Year)		Muncas egistrar's Signa				e, Marylan	d 20855	
	Registr:	_	11 1 1 0 20		the signi	19	howthe	ŧ			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 12:20 A TEK /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner DOCTORS COMMUNITY HOSPITAL LANHAM PRINCE GEORGES 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 1**∑**M 2□F Days Hours Yrs. Director 231-23-4429 50 MARCH 11,1954 CAMBODIA Usual Residence of Decedent 10a, State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Madical Examiner must be notified at Director 1 Yes 2 □ No PRINCE GEORGES NEW CARROLLTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ or Itams 23a WESTBROOK DR. 6301 20784 Funeral CAMBODIA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☑ Married ☐Yes 2XNo 1 ☐ Yes 2 X No Specify: à If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced natural, ASIAN Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if itam 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) 9 CUSTODIAN P.G.CO. SCHOOLS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ၉ CHROUN TEK RETH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SILVIA TEK/WIFE 6301 WESTBROOK DR., NEW CARROLLTON, MD. 20784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY June 6,2004 RIVERDALE, MD. 21. Signature of Funeral Service Ocensee any ir CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death

6 MONTHS Immediate Cause (Final METASTATIC GASTRIC CARCINOM **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a someoquenes of): Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760. Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No ō Year Month Day 4 Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2/ No 1 ☐ Yes 2 ☐ No tha Hospital or Attending Physician: director 25. Was case referred to medical 26. Place of Death Check onl one examiner's Other: 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature ap 29d. Date signed (Month, Day, Year) 20 D24093 allens no 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARK PARKHURST mo 5711 SARVIS AVE 200 RIVERVALEND 20737 31. Date filed (Month, Day, Year) 32. Registrar's Signature JUN 0 8 2004 sacks! Registrar

			For State	State of	f Marylar	-	artment <i>rtificate</i>			and M	ental Hy	gien Reg. N	-	ş	000	F7 0
			Registrar 1. Decedent's Name (First, Middle, L	ast)			imouto		Journ		2. Date of De	ath	***************************************	I.E	3. Time of	Death
	Physici /Medic				MPSON								2004	ear	7:45	АМ
	Examir	ner	4a. Facility Name (If not institution, gi 516 Bickford		nber)				Location o			40	County of MONT		AEDV	
	Funeral			Sex	7. Age (In yrs.	, ,	If Under 1	Year	If Under 2		8. Date of Bi	rth Von		Birthol	ana (State or	Foreign
	Director		214-46-7063	1 □ M 2 💢 F	78	Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, D. NOV • 1	0,1	925	Mai	ylan	d
	land ow		Usual Residence of Decedent 10a. State 10b. County			ty, Town or Lo	cation							10	Od. Inside City	y Limits
	e-fsh	ctor	MD Mon	tgomery	Y		Roc	ckvi	llle						1 ∑ Yes	2 🗌 No
	be filed within 72 hours after death with the Maryland tal Hygiene d other then "netural", or items 23e or 28e-f show event, the Medical Exercities must be notified at	I Director	10e. Street and Number 516 Bickfor	d Lane			10f. Zip (0850			10g. C	U.S.		try?	
	ems 2	Funeral	11. Marital Status	12. Was Dece	ident Ever in U	J.S. 13.	Was Decede	ent of His	spanic Orig	gin? (Spe	cify Yes or No Rican, etc.)) -	14. Race -			
330	filed within 72 hours after Hygiene. ther then "netural; or fte ont, the Medical Examina	by Fu	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	1 ☐ Yes If Yes, Giv Year or Da	е		1 □ Yes 2	_			,		Specify:			
3-003p	72 hou netura lical E		15. Decedent's 8	ducation		16a. Dece	dent's Usual	Occupa	tion	of working	10	16b. F	Kind of Busin	ess/ind	ustry	
Z	within ne. hen "	Completed	Elementary/Secondary (0-12)	College (1	-4or 5+)		kind of work DO NOT use teria				<i>,</i> g		Monto		Co.	
N D	filed y Hygie other I		17. Father's Name (First, Middle, Las	t)		Care	CCTIC				(First, Middle		Schoo) I S		
yland	2 should be and Mental is marked o	To Be	Henry Campb	ell							a Sew					
Mar	nd 2 sho lth and 27 is m		19a. Informant's Name/Relationship Emmanuel Thomp		I (Son)					Route Numb					
e,	of Hea		20a. Method of Disposition 1XX Burial 2 Cremation 3		20b. I	Place of Dispo	sition (Name	e of her place) [[]	D	ate	20c. L	ocation - Cit	y or Tov	wn, State	
Saltimore	Page thent tent: fi		'4 □ Øonation 5 □ Other (Speg	(y) /	Pl	easan,									cg, Mi	
Da	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other treumetic every injury or other treumetic every.		21. Sign tyle of Funeral Service US	AMA	well						WDEN ,Rock					· fi
Г			23a Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that co	aused the deal	th. Bo not ent	er the mode	of dying	, such as o	cardiac o	r respiratory a	rrest,			Approximate Interval Betw	reen .
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)		ancer		ng								Onset and Do Onths	eath
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	e ii	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consec	quence of):										
•	xecute and al-trans	Examine	that initiated events resulting in death) Last	c	or as a consec	quence of):										
00/0	death certificate be executed e attending physician and id for use as the burial-transit	dical E		d												
00 ×	ertifica ling ph e as th	d)	IF FEMALE:													
200	leath certific attending p	Physician/M	23b. Was decedent pregnant in the past 12 months?		come of pregna irth 2 ☐ Feta ant at time of c	aldeath 3□	Ectopic pre						23d. Date of Month			ear se
)	of the d by the tachec	hysl	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkno	own											
ds,	w requires that the de been signed by the should be detached	by	Part II. Other significant conditions	contributing to de	eath but not res	sulting in the u	ndertying cau	use give	n in Part I.			obacco Yes 2			e cause of de bly 4 □Ur	
spiosa	G S CA	ompleted									24a. Was		24b. Wer	e autop	sy findings av	vailable
	T ate	Com									autor perfo	rmed?	deat	h? Yes 2	pletion of cau 2□ No	129 01
V II d	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital:							(Check only o					
		P=	1 ☐ Yes 2X No 27. Manner of Death	28a. Date o	of Injury	ER/Outpatien 28b. Time of		c. Injury Work	°4□Nur at		ne 5 ½ Resi			Specify)		
0	Attending F death. ctor: After y the funera	atio	1 Natural 5 Pending investigate	on	h, Day Year)	Injury	М		es 2 N	40						
DIVISION OF	al or Atten after deat Director: d in by the	Certification:	3 Suicide 6 Could not 4 Homicide determine	286. Place	of Injury - At h ng, etc. <i>(Specil</i>	ome, farm, str fy)	eet, factory,	office		2	8f. Location (City or To	Street ar	nd Number o e)	r Rural	Route Numbe	θ <i>Γ</i> ,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Afte completely filled in by the fune	edical C	(Check only 2 Medical Exa	hysician: To the miner: On the ba	asis of examina	owledge, death	occurred at	t the time	e, date and	i place, a h occurre	nd due to the	cause(s) and manne d place, and	r as sta	ted.	
	within 2 To the Complet	Med	one) 29b. Signature and title of certifier	and mann	ner stated.			License					te signed (M			
	[]		> for A	h	/	ソク		D2	2051	6			ne 3,			
			30. Name applied address of person who						D. 7	g 10	200	D-	1		MD C	0050
	₹ Sta	to	Joel Schulma 31. Date filed (Month, Day, Year)		D . 60 egistrar's Signa	000 Ex	ecut	ıve	RTAG	ı, #	300,	KOC	KATTI	.e,	שט 2	0852
	Registr		JUN 0 7 20	1.	www	4	Soon	6								

DOS '		1- For Unpend Item #23a,27,28a-f per me 6833 //28/04 t	Mental Hy as	rgiene
	ysician Medical	1. Decedent's Name (First, Middle, Last) Eloisa Del Carmen Urbina	2. Date of De Month	path Day Pear 0533 a M
	aminer		⊥ May 3	2004 4c. County of Death Prince Georges
Dire	eral	5. Social Security Number 216-69-6206 1 M 2XIF 7. Age (In yrs. last birthday) Yrs. 1 If Under 1 Year If Under 24 Hr Months Days Hours Mir 1 Usual Residence of Decedent		th ay, Year) 9. Birthplace (State or Foreign Country) Maryland
e Maryland	uffied at	10a. State 10b. County 10c. City, Town or Location Laurel		10d. Inside City Limits
ath with th	ral Dire	10e. Street and Number 14720 Forrest Street # 101 20707		10g. Citizen of What Country? United States
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Important: If item 271s marked other then "natural; or Items 23s or 28s-1 show	it, the Medical Exeminer must be notified Completed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue) 15. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Pue 16. Yes 2 □ No Specify: Mexican		14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036 to 2 should be filed within 72 hours aft thit and Mental Hygiene.	the Medical	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) None	orking	16b. Kind of Business/Industry
Vland 2 Vland be filed Mental Hygi	To Be Co	17. Father's Name (First, Middle, Last)		Maiden Sumame) ajales
e, Mary I and 2 sho feelth and i	her treume	19a. Informant's Name/Relationship (Type, Print) Jorje Urbina/ Father 19b. Mailing Address (Street and Number or Father) 14720 Forrest Street Laurel, MD 20707	# 101	er, City or Town, State, Zip Code)
Baltimore, permit. Pages 1 ar Department of Hea mportent: If item	njury or ot	Majoriai Park		20c. Location - City or Town, State Laurel. MD
Dan Derm	any I	21. Signature Funeral Service Licensee 22. Name and Address of Facility Columbia Mortuary P.O. Box 5800 Wa. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.		
Physician and physician physician and physician physicia	the burial-transit each dical Examiner	Immediate Causa (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Sudden Unexplained Death in Infance Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.		Interval Between Onset and Death
Division of Vital Records, P.O. Box 6(9 Hours afterding Physician: The law requires that the death certific 24 hours after death. 9 Funerel Director: After this certificate has been signed by the attending p	page 2 should be detached for use as completed by Physician/Mer	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ □ Unknown		23d. Date of delivery Month Day Year
cords, P.O. B. w requires that the death	ould be deta	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		obacco use contribute to the cause of death? 'es 2 5 10 3 1 Probably 4 Unknown
ial Reconstruction The law reficate has be	or, page 2 sh		24a. Was autop perfor 1. Yes	sy prior to completion of cause of
n of Viting Physicia	neral director	1 XYes 2 No Hospital: 1 Inpatient 2 ER/Outpatient X DOA Other: 4 Nursing H		ence 6 Other (Specify) ow injury occurred
Division of Vital Re To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha	led in by the funeral	2 Accident 3 Suicide 4 Homicide 2 Accident 3 Suicide 4 Homicide 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) found at home		n treet and Nymber or Rural Route Number, n, State) 1470 4th Street,#1 (Mary Land
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T with or	N	29b. Signature and little of certifier Jasha 3 Greenberg ND 20c. License number OCME	1	29d. Date signed (Month, Day, Year) [ay 31, 2004]
	Chat	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Tasha Z (Yelnberg M. D 31. Date filed (Month, Day, Year) 32 Gegistrar's Signature	et, Balti	more, Maryland 21201
Re	State gistrar ,	JUN 1 1 2004 Some & Sparks		

			1 - For State Registrar	State of Ma	aryland / Depa	artment of		-		2006	200	152
- 6		5	Decedent's Name (First, Middle, Last)			timodio o	Doutin	2. Date of De	Reg. No.	- C () -9	3. Time of	Death
Į,	Physici		ISABELLE	SMITH	WILSO	N II	LRICH	Month	17. Day	2004		. 14
>	/Medic Examir		4a. Facility Name (If not institution, give		112200		or Location of Dea			County of Death	1:45	AM
	Examir	ier	Stella Maris					uı	40. 0			
	Funeral		5. Social Security Number 6. Sec		(In yrs. last birthday)	If Under 1 Yea	imonium	8. Date of Bir	th	Baltin	nore place (State o	v Foreign
Ý	Funeral Director			M 2 X)F	88 Yrs.	Months Day			/1°91	Cou	N York	
			Usual Residence of Decedent					0,1)	/ 4 74	.0 2461	A TOTT	7
	/land		10a. State 10b. County		10c. City, Town or Lo	cation	100				10d. Inside Cit	ty Limits
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	the 289	Director	10e. Street and Number			10f. Zip Code		July 1	10a. Citiza	en of What Cour	ntry?	
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	eath	Funeral		12 Was Doodont F		Mac Decedent of				Lited S		3
	iterr	Ë	1 Never Married 2 Married	Armed Forces?		f Yes, specify Cu	Hispanic Origin? (ban, Mexican, Pue	nto Rican, etc.)		Black, White,		
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21215-0036	72 hours alter death with the Maryland natural', or items 23a or 28e-1 show disal Examiner must be notilled at		15. Decedent's Edu		16a Dece	tent's Usual Occ	unation		16b Kin	of Business/In		
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2	within iene. than "	E C	Elementary/Secondary (0-12)	College (1-4or 5-	+)		Operato					
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an	ntal od o	Be	, , , ,	milton	Wilson							
Maryland	s 1 and 2 should be filed within 72 hours atter death with the Marylan I Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23e or 28e-f show other treumatic event, the Medical Examiner must be notified at	ပို	19a. Informant's Name/Relationship (Ty				Get C	rgina		Monte	comery	<u>r</u>
Za	d 2 shc th and 7 is m treum				tep 19b. Mailir		et and Number or R	ישוועא פועטר וביע				
	1 and 1 Health em 27 ther tr		Kathleen Altenb 20a. Method of Disposition	urg/ nau	20b. Place of Dispo		star HII	Date		rretts		, Md.
Baltimore,	Pages nent of I ent: If its ury or o		1 Burial 2 □ Cremation 3 □ R	emoval from State	cemetery, cren	natory or other pi				ation - City or To		
Ë	permit. Pages Department of Importent: If i any injury or once.		'4 □Donation 5 □Other (Specify)	, ,	Baltimon	e Ceme	etery 6/	19/04	Balt	imore,	Mary	land
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			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused e cause on each lin	the death. Do not ent	er the mode of dy	ring, such as cardia	c or respiratory ar	rest,	1,700,711,000,110	Approximate Interval Betw	
Va.	Physician	Ř A	Immediate Cause (Final disease or condition	Athe	rosclero	hic C	archivas	cialar	Dis	ease	Onset and D	eath
	/Medical		resulting in death)		consequence of):			c-[co(.				
l.	Examiner		P									
F	The same of	ner	Fequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):							
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ó	an al	Ä	resulting in death) Last	Due to (or as a	consequence of):							
8760,	cate be executed physician and the burial-transit	dicai	d									
9	tifica ng ph as th				171				e- 1			
Вох	eath certific attending p	S S	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of		Ectopic pregnan			23	d. Date of delive	эгу	
<u>m</u>	deat e att	icia	in the past 12 months? 1 □ Yes 2.⊠No	4☐Pregnant at t		Other (specify)	cy			Month	Day Y	ear
P.O.	that the de led by the a detached f	hys	9 Unknown	9□ Unknown								
	The law requires that the death certificate has been signed by the attending I agge 2 should be detached for use as	by Physician/Me	Part II. Other significant conditions con	tributing to death bu	t not resulting in the ur	iderlying cause g	iven in Part I.	23e. Did to	bacco use	contribute to th	ne cause of de	ath?
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ō	Phys this ral di	-	1 ☐ Yes 2 No 27. Manner of Death	1 ☐ Inpatier 28a. Date of Injury		1 3 □ DOA 28c. Inju	ther: 4 Nursing H	fome 5 ☐ Resid 28d. Describe h	ence 6[Other (Specify	()	
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	To the Hospitel or Attending Phywithin 24 hours atter death. To the Funeral Director: Atter this completely litled in by the funeral completely litled in by the funeral completely litled in by the funeral completely litled in the	Medical	29h Signature and title of certifier	and manner stat	ea.	29c Licen	isa number		Od Data	igned (Month)	Day Vass)	
	7. w 0	-	200. Signature and title of Cartinal			230. Licen		_	.au. Date s	signed (Month, L	Jay, rear)	
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	(5)		30. Name and address of person who co	mpleted cause of de	ath (Item 23a) (Type, I	Print)	1 N	1001 - n		7 1.	40 ac	221
			TARIG MALL	MOUI) -	ath (Item 23a) (Type, I	SUCK	CIVY !	rece 16	41	Salt'	Dan	
	Sta		31. Date filed (Month, Day, Year)	32. Registra	s Signature	1	~					
	Registr	ar	JUN 23	LUUT P JE	Estela a 18	Barrele	01 3					İ

DHMH 17 Rev 1/2001

2004

JUNE 17,

ULRICH, ISABELLE

JUAN RAMIRO LOPEZ VELAZQUEZ umpend item#23a,27,28a-f,PER ME,G832,6/30/04eg UNK 04-182 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-03457 State of Maryland / Department of Health and Mental Hygiene For State Registrar R.T Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year Juan Ramiro Lopez Velazquez /Medical May 22 2004 1102 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Her 1 Year If Under 24 Hrs. Johns Hopkins Hospital 7. Age (In yrs. last birthday) 31 Yrs. 5. Social Security Number **Funeral** Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months 1 MM 2□ F Hours none Director Yrs. 8/08/1972 Mexico Usual Residence of Decedent Manyland 10a State 10b. Count 10c. City, Town or Location ref, or items 23a or 28e-f show Examiner must be notified at 10d. Inside City Limits MD Baltimore Director 1 Yes 2 □ No the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 512 South Collington Ave. 21231 Mexico Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 2 should be filed within 72 hours after of and Mental Hygiene. Is marked other than "neturel", or Iter Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2□ No Specify: 3 ☐ Widowed 4 ☐ Divorced Mexican White treumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Laborer Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)
Estela Velazquez Bazan Be Armando Lopez Martinez ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 item 27 Alberto Lopez/Brother 512 Collington Ave. Baltimore, Md 21231 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ō <u>=</u> 1

■ Burial 2

□ Cremation 3

□ Removal from State Department of Important: If any injury or once. 6/12/04 Cem.San Pedro Puebla, Mexico `4 ☐ Donation 5 ☐ Other (Specify PHILIP D.RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Drowning complicating alcohol intoxication Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. East Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physicien: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No Be Completed 1 ☐ Yes 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 □ No has autopsy performed? 12 Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Hospital: Other: P 1 XYes 2 □ No 1 Inpatient 2 R/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) filled in by the funeral Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending 10:22a death. 5/22/04 investigation 1 ☐ Yes 2 🛣 No subject fell in harbor 2X Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Baltimore, Marylnad within 24 hours a To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) To the 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) OCME May 23, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

State Registrar

32. Registrar's Signature 2004

MID

JACK M. TITUS 31. Date filed (Month, Day, Year)

JUN 07

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			1 - For State Registrar	State of Marylar		artment of rtificate of		-	giene Reg. No	2001	20054
	Physici	an	1. Decedent's Name (First, Middle, Las	t)				2. Date of De. Month	ath Da	y Year	3. Time of Death
	/Medi		James Thomas Whi					June	5,	2004	1:26 P M
1	Examir	ner	4a. Facility Name (If not institution, give				or Location of Deat			County of Death	
	Euraval		Calvert Memorial 5. Social Security Number 6. Se		(ast hirthday)	If Under 1 Year	Frederick	B Date of Birt	h	alvert (
	Funeral Director			X ^M ^{2□} F 61	Yrs.	Months Days		Nov. 30	y, Year)	942 Mary	place (State or Foreign ntry) land
	p.		Usual Residence of Decedent								
	show	<u>_</u>	10a. State 10b. County		ty, Town or Lo	cation					10d. Inside City Limits
	he M	Director	MD Calvert 10e. Street and Number	County Ch	esapea	ke Beach		1			1 ☐ Yes 2 🙀 No
	with I		4575 Christiana F	Parran Road		10f. Zip Code 20732			-	izen of What Cou	ntry?
	has 23	Funeral	11. Marital Status	12. Was Decedent Ever in U	l.S. 13. V			pacify Yas or No.		14. Race - Ameri	can Indian
ပ္	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Intropretant: If item 27 is marked other than "natural", or Items 23a or 28a-f show may injury or other traumatic event. Its Marked Examinat must be notified at once.	F	1 ☐ Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ➡ No If Yes, Give	1		Hispanic Origin? (S oan, Mexican, Puert	o Rican, etc.)		Black, White,	etc.
Š	raf', c	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give 25 Year or Dates:		I□Yes 2ሺNo	Specify:			Specify: Whi	.te
بر ب	72 h	Completed	15. Decedent's Edi (Specify only highest grad		16a. Deced	lent's Usual Occu kind of work done	pation during most of wor	king		nd of Business/In	
13	within ane.	du	Elementary/Secondary (0-12)	College (1-4or 5+)					Pri		ge's County
2	Hygie Hygie ther I		17. Father's Name (First, Middle, Last)	5+	Admin	Istrator	/Vice Pri	ne (First, Middle,	Maidon		Schools
Maryland 21215-0036	d be ental ked o c eve	To Be	James H. White					is Post	Walder	Sumame)	
37	should Ind Men	-	19a. Informant's Name/Relationship (T)	ype, Print)	19b. Mailin	g Address (Street			r. City o	r Town, State, Zic	Code) 20732
	alth a		Donna H. White (V	Wife)			na Parran				
J.	as 1 a of He of He litem		20a. Method of Disposition		Place of Dispos	sition (Name of natory or other pla	7			cation - City or To	
Ĕ	Pages nent of l ant: If its ury or o		1 ☐ Burial 2 X Cremation 3 ☐ F 1 ☐ Donation 5 ☐ Other (Specify,	nemovanioni State _	e Crem			004	Cli	nton, Ma	ryland
Baltimore,	permit. Departr Imports any inju		21. Signature of Fun	1/w	22	. Name and Addre			al H	ome Calv	ert, P.A.
_	g0 = g a	-	Michael X. Le	e/-	81	25 South	ern Marvl	and Blvo	d (
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	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Metasta	tic ac	Penocarci	nomu of	the 1	2007	ate	Onset and Death
	Examiner			Due to (or as a consequence	uence of):						
		ē	Sequentially list conditions, and cause. Enter Underlying Cause. (Disease or injury	b. Due to (or as a consequ	nenna af):					-	
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o,	an an rial-tr	Exa	resulting in death) Last	Due to (or as a consequ	uence of):						
8760,	icate be executed physician and s the burial-transit	dlcal		d							
<u>ფ</u>	artifica ing pl	Med	IF FEMALE:						-		-1555
Вох	eath certiff attending for use as	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1□Live birth 2□Fetal	Ideath 3□	Ectopic pregnanc	y		2	3d. Date of delive Month	ory Day Year
o.	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of de 9□ Unknown	eath 5□	Other (specify) _				WORL	Day Teal
۵.	The faw requires that the death certific the faw requires that been signed by the attending page 2 should be detached for use as	by Physician/Med	Part II. Other significant conditions co	ntributing to death but not resi	ulting in the un	derlying cause on	ven in Part I.	23e. Did to	bacco u	se contribute to th	e cause of death?
ds,	uires sign			, and the second	•	,			es 25		ably 4 □Unknown
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æ	he far e has age 2	Completed						autops	sy	prior to cor death?	osy findings available appletion of cause of
ta	Physician: The la r this certificate has ral director, page 2	a)	25. Was case referred to medical				26. Place of Dea		252 No	1 🗆 Yes	2.EX.No
⋛	ysici is cer direct	OB	examiner?	Hospital: 15 Inpatient 2 🗆	ER/Outpatient	3□ DOA Oth				Other (Specify	()
0	ig Ph ter th	n: T	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor		28d. Describe ho			/
Ö	Attending Physician: ri death. ector: After this certifice by the funeral director,	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Workin, Day 7 dai)	nqury		Yes 2 □ No				
-	- 9	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, stre	et, factory, office		28f. Location (St City or Town	treet and n, State)	Number or Rura	Route Number,
Ω	oital cours af oral Distriction	S	<u> </u>			·					
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 ☐ Medical Exemi	sicien: To the best of my knowner: On the basis of examinat	wledge, death tion and/or inv	occurred at the tirestigation, in my o	me, date and place, pinion, death occur	and due to the ca red at the time, d	ause(s) a ate and	and manner as sta place, and due to	ated. the cause(s)
	o the o the omple	Me	29b. Signature and title of certifier	and manner stated.	<u></u>	29c. Licens	e number	2	9d. Date	signed (Month, L	Dav. Year)
	- s - ó) Done	Ton lo mo		DH	7612			e 6, 2	
	_	-	30. Name and address of person who co	ompleted cause of death (Item	23a) (Type, F)	
	. Tai	- 1				-					
	ַט		David J, Tardio, Month, Day, Year)	M.D. 110 Hosp 32. Registre's Signat	oital R	d., Suit	e 310. Pr	<u>ince</u> Fre	eder:	ick, MD	20678

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year **Physician** ELIZABETH ROSE WOOD JUNE 8, 5:15 P. 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ALLEGANY COUNTY NURSING HOME CUMBERLAND ALLEGANY If Under 1 Year If Under 24 Hrs. Months Days Hours Min. (Month, Day, Year) OCT • 23,1897 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1□M **2**□F 212-38-5394 WEST VIRGINIA 106 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural; or Items 23s or 28s-f show other traumatic event. The Modified at XXYes 2 No Director ALLEGANY CUMBERLAND 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with 9 N. CHASE STREET U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: WHITE à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) MARYLAND College (1-4or 5+) Elementary/Secondary (0-12) STATE ROADS SECRETARY 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be es 1 and 2 should be fi of Health and Mental H fitem 27 is marked ot JOSEPH MORGAN WOOD MARGARET LEGORIA KADEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT WOOD / NEPHEW 929 RIDGEDALE AVENUE, CUMBERLAND, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition Pages 1 Burial 2 Cremation 3 Removal from State ö permit. Page Department of Important: If eny injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) SS. PETER & PAUL CEM. 06/12/2004 CUMBERLAND, MD 21. Signature of Funeral Service Licenses ²² UPCHURCH FUNERAL HOME, P.A. 202 GREENE STREET, CUMBERL, 23a. Part 1. Enter the disease, or commication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one can be pn each line. 202 GREENE STREET, CUMBERLAND, MD 21502 Approximate interval Between inset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner 1105C Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, signed by the attending physicien I be detached for use as the buria Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 20 Ho Month Day Year 4☐Pregnant at time of death 5 Other (specify) page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 2 XNO 1 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed^a 1 ☐ Yes 20X No 1 ☐ Yes 2 ☐ No ours after death.

nerel Director: After this certific filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 ursing Home 5 Residence 6 Other (Specify) Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide within 24 hours a To the Funerel C Fortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of Cartifier 8 rson w o p impleted cause of death (Item 23a) (Type, Print) Road, Cumberland nas M.D. Oldtown 517 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2004 Year June 3, **Physician** 7:00 P.M Harriet Mae Wilburn /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Accident Garrett 27129 Garrett Highway If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Sept 19, Birthplace (Stete or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) , 1905 Maryland **Funeral** Days Hours 1 ☐ M 2 🕱 F 213-40-3794 98 Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23s or 28s-f show any injury or other treumatic event, the Medical Example masses. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo MD Garrett Accident 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 27129 Garrett Highway 21520 USA Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 2 No Specify: ð 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Public Schools School Teacher 8 th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Laetitia Friend David Owen DeWitt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Merrell E. Wilburn/husband 27129 Garrett Highway, Accident, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Hoyes U.M. Cemetery, June 6, 2004 Friendsville, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral/Service Line Newman Funeral Homes, P.A., PO Box 275 Rumaci 179 Miller St., Grantsville, MD 21536 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Coronary Artery Disease years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any leading to innectiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed use as the burial-transit attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death Day Month Year in the past 12 months?
1 Yes 2 No be detached for 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown cate has been signated to page 2 should to 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2□ No 1 🗆 Yes this certificate 1 ☐ Yes 2 No Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Tes 2 No 2 ER/Outpatient 3 DOA Medical Certification; To 28c. Injury at Work? funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner Death After 5 Pending 1 I atural 1 🗌 Yes 2 🗌 No death. nerel Director: A filled in by the fu investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 / Homicide ŏ To the Hospitel within 24 hours a To the Funerel I Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cartifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas G. Johnson, M.D. 311 N Fourth St Oakland, MD 21550 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

2004

			1 - For State Registrar	State of Ma	ryland /		ırtmen <i>tificat</i>			ınd M		giene Reg. No:		20053
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	/Medic Examir		4a. Fecility Name (If not institution, give Memorial Hospi	street and number)	 			Town, or	Location o	of Death	may 20	4c.	County of Deer Allegar	th
	Funeral Director		5. Social Security Number 6. S	9x 7. Age	(In yrs. last	birthday) Yrs.	If Under Months	1 Year Days	If Under a	Min.	8. Date of Birt (Month, Da 04/18/1	h y, Year) .924	Co	thplece (State or Foreign buntry) ryland
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	3/1VA		30. Name and address of person who					0./ ==	0 -	OF -	, -		D 01500	
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		4	For State Registrar	State of Mar		artment of H		nd Mental Hy	giene	1 20050
			Registrar Decedent's Name (First, Middle, Las	it)		timouto or E		2. Date of De	ath	3. Time of Death
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	Euporal		5. Social Security Number 6. S		(In yrs. last birthday)	If Under 1 Year	If Under 2	4 Hrs. 8. Date of Bi		Birthplace (State or Foreign Country)
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	3a or 28e	Funeral Director	10e. Street and Number 25801 Shady Land	e, Apt. 102	2	10f. Zip Code 215	62		10g. Citizen of WI United	the state of the s
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic svent, the Medical Examinational be mailified at once.	by Funer	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ender Armed Forces? 1 Yes 2 No Hyper Year or Dates:	3	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2€No	ispanic Orig n, Mexican Specify:	gin? (Specify Yes or No , Puerto Rican, etc.)	14. Race Black Specify:	- American Indian, , White, etc. white
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	T ¥ S		Hall X	7	MP.		25759		June 2,	
			30. Name and address of person who	completed cause of de	eath (Item 23a) (Type	, Print)				
			Walter K. Naumann	. M.D., PO	Box 247.	106 Cemet	tery I	Road, Accid	ent MD 2	1520-0247
	St Regist	ate trar	31. Date filed (Month, Day (Month)	2 2004 Registre	r's Signature	And				

			For State Registrar		State o	f Marylan	-	artmen rtificate				ental Hy	giene	00	l,	200	59
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be executed	ian ar urial-t		resulting in death) I	Last	Due to	(or as a conseq	uence of):										
orou,	physic the bi	dicai		,	d												
The law requires that the death certifica	been signed by the attending physician and should be detached for use as the burlal-transit	Physician/Med	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 [9 ☐ Unknown	months? ☐ No	1 Live b	tcome of pregna birth 2 Feta nant at time of d own	Ideath 3	Ectopic pr Other (sp					2	3d. Date o		•	'ear
that th	ed by detac	Ph	Part II. Other signif		s contributing to d	eath but not res	ulting in the u	nderlying c	ause give	n in Part I.		23e. Did	tobacco us	se contribu	ute to the	e cause of de	eath?
Se la	ngis n lid bla	d by										10	Yes 2]No 3(📋 Proba	ibly 4	inknown
aw requir	s bee	ompieted										24a. Was		24b. We	re autop	sy findings a	available
T lag	ite ha	E O										perfe	ormed? 2 X No	dea	th? Yes		.030 01
ician:	ctor. p	BeC	25. Was case refer examiner?	red to medical								(Check only					
OI VIIA Physician:	his ce I dire	10	1 XYes 2□				ER/Outpatier					ne 5□Res			(Specify)	
ling P	After t unera	i o	 Manner of Deat Matural 	5 Pending		of Injury th, Day Year)	28b. Time o Injury	r 2	8c. Injury Work	at ? ∕es 2 🔲 I	1	28d. Describe	now injury	occurred			
Attending r death.	the f	icat	2 Accident 3 Suicide	investiga 6 🗆 Could no	ot be	of Injury - At he	ome, farm, sti			03 20		28f. Location (Street and	Number (or Rural	Route Numb	ber,
after after	d in by	Certification	4 🗋 Homicide	determin	buildi	ing, etc. (Specif	y)	, , , , , ,	,			City or To	wn, State)				
the Hospitei or	To the Funaral Director: After this certificate has completely filled in by the funeral director, page 2 or	ledical C	29a. Certifier (Check only one)	Certifying	Physicien: To the xeminer: On the b and man	best of my kno asis of examina ner stated.	owledge, deat tion and/or in	h occurred vestigation,	at the tim	e, date an inion, dea	d place, a	and due to the ad at the time,	cause(s) and	and manni place, and	er as sta I due to	ited. the cause(s)	
To the within	To th	Me	29b. Signature and	title of contidier	1			290	. License	number			29d. Date	signed (/	Month, E	Day, Year)	
	-			Ur.				I	H2615	54			JUNE	3, 2	2004		
4)		30. Name and addr	ess of person w		se of death (Iter	n 23a) (Type, 69 WO]		RES I	DRIVE	O,	AKLAND,	MD	21550)		
	Sta Registr		31. Date filed (Mon		32. F	Registrar's Signa	ature	Snack									
				11	0 2001	5.473 WAR A	EF.	CARROLL.	13								

				State of Maryland	Department of Health and N	•	_
				1 - For State Registrar	Certificate of Death	Reg. N	anni annan
74	J	Physici	an	1. Decedent's Name <i>(First, Middle, Last)</i> Pauline Elizabeth William	icon	2. Date of Death Month Da June 13,	2004 79 ar 0648 a M
1		/Medio		Pauline Elizabeth William 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		2004 0648 a M
W)	1	Examir	ıer	Harford Memorial Hospital	Havre de Grace		Harford
1		Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month Day Year APTIL 10,	
9		Director		220-24-1437 1□ M 2♥ 75 Usual Residence of Decedent	Yrs. Months Days Hours Min.	April 10,	1929 Maryland
D648 A.M		with the Maryland is or 28e-f show the notified at	tor		own or Location Tre de Grace		10d. Inside City Limits 1 □XYes 2 □ No
00		r 28e	Funeral Director	10e. Street and Number	10f. Zip Code	10g. C	itizen of What Country?
64		th wit	alD	102 Weber Street	21078		U.S.A.
0		r dea	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
120	5-0036	ours afte ral', or It Evamin	þ	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2X No Specify:		Specify: White
1	15-0	in 72 h	Completed	15. Decedent's Education (Specify only highest grade completed)	6a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ing 16b. F	Kind of Business/Industry
	212	d with giene. r thar	E O	Elementary/Secondary (0-12) College (1-4or 5+) 12 0	Assistant Manager		Sales
6	Maryland 2121	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other treumatic event, the Medical Examinar must be notified at any injury or other treumatic event, the Medical Examinar must be notified at angle.	To Be C	17. Father's Name (First, Middle, Last) UNK		e (First, Middle, Maide) nce Edna St	
pr-	Aary	2 short and h			9b. Mailing Address (Street and Number or Run		
01		1 and Health iem 27		Raymond R. Williamson (Spouse) 20a. Method of Disposition 20b. Place	of Disposition (Name of	e de Grace,	, Maryland 21078 ocation - City or Town, State
17	mo	Pages nent of nnt: If it			tery, crematory or other place) 1. Chapel Cemetery 6/17		urchville, MD
DoB	Baltimore,	permit. Departn Importe any inju		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Tarring-Cargo Funer Aberdeen, Maryland	al Home, P.	.A.
4)				23a. Part1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line.	o not enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
		Pnysician	0 1	Immediate Cause (Final disease or condition	(Comia		Onset and Death
41	1	/Medical Examiner		resulting in death) Due to (or as a consequence)	ee of):	+	
1			Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	menic mand		
70%		be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	noscleritic Ca	refreren	In duano
yos we	760,	te be execu ysician and ie burial-trai	cal Ex	545 15 (51 45 4 55) 1544511	nie Renal his	01	,
13	687	ys e		d	nic Kenal his	"ufficient	
177	Box (h certifica ending ph	In/Me	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dec	uth 3 Ectopic pregnancy		23d. Date of delivery
3	o.	res that the death certifica igned by the attending ph be detached for use as th	Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 4 □ Pregnant at time of death 9 □ Unknown 9 □ Unknown	5 Other (specify)		Month Day Year
112ABETH	s, P	requires that the een signed by th nould be detache	by Pi	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.		use contribute to the cause of death?
4	Records,	requii	Completed			1 ☐ Yes 2	
12	Rec	2 3	mp			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
U	la	sician: Th certificate rector, pag	e Co	25. Was case referred to medical	00 Place of Death	1□ Yes 2ŪNo	
L	of Vital	Physician: this certific ral director,	0 B	examiner? 1 Yes 2 No Hospital: 1 Impatient 2 ER/	Other	n (Check only one) me 5 □ Residence	6 □Other (Specify)
3			n: T	27. Manner of Death 28a. Date of Injury 28th		28d. Describe how inju	
PHLINE	Sior	Attending r death. ector: After	catlc	2 Accident investigation	M 1 Yes 2 No		
5	Division	s after de s after de al Directi ad in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	28f. Location (Street ar City or Town, State	nd Number or Rural Route Number, a)
		To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical (29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowled 2. Medical Examiner: On the basis of examination and manner stated.	ge, death occurred at the time, date and place, and/or investigation, in my opinion, death occurr	and due to the cause(s ed at the time, date and) and manner as stated. d place, and due to the cause(s)
		To th withir To th comp	Me	29b. Signature and title of defitier	29c. License number		te signed (Month, Day, Year)
)	-) JVW	D 20212		6/13/2004
		5		30. Name and address of person who completed cause of death (Item 23)		tanel go	2016 Cm 010
		Sta Registr		31. Date filed (Month, Day, Year) 32. Regional Signature JUN 1 5 2004			

DHMH 17 Rev 1/2001

			For State of Maryland /	Department of Health ar	nd Mental Hygie	ne
			Registrar	Certificate of Death	Reg.	NO: 004 20061
	Physic	an	1. Decedent's Name <i>(First, Middle, Last)</i> Mildred Emma	TT .	2. Date of Death Month	Day Year 3. Time of Death
	/Medi		Mildred Emma 4a. Facility Name (If not institution, give street and number)	Watson 4b. City, Town, or Location of I	June 10	, 2004 6:09P M
	Examir	ier	4210 Largo Road	Upper Marlbon		Prince George's
	Funeral		Social Security Number	irthday) If Under 1 Year If Under 24	Hrs. 8. Date of Birth	
	Director		220-16-8844 ^{1□ M 2} 7 95	Yrs. Months Days Hours	Min. (Month, Day, Ye	
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City. Toy	wn or Location	oune 20;	- J
	the Marylan 28a-f show	ρ	M 7 1 D 1 C 1	er Marlboro		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	or 28a	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	th wit	al D	4210 Largo Road	20772		U.S.A.
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other then "naturel", or Items 23a or 28a-f show or other traumatic svent, the Medical Examina	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Moridowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Never Married 2 Never Married 2 Never Married 3 Never Married 4 Divorced	13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F	n? (Specify Yes or No- Juerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
2-0	72 hc	Completed	15. Decedent's Education 16a (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most or	f working	o. Kind of Business/Industry
121	within ene. then "	mp	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired) Operator		Db C
d 2	filed with Hygiene. other ther		17. Father's Name (First, Middle, Last)		Name (First, Middle, Maid	Phone Company
lan'	s should be filed within and Mental Hygiene.	To Be	Wesley B. Binger		ssie C.	Webb
Maryland	2 should and Men is marke sumatic	-		b. Mailing Address (Street and Number of	or Rural Route Number, Cit	ty or Town, State, Zip Code)
	is 1 and 3 feeth item 27 other tra	1	Donna Young (Granddaughter)	12822 Simpson Driv		
Baltimore,	Pages 1 nent of H int: If ite		1 ☑ Surial 2 ☐ Cremation 3 ☐ Removal from State cemeter	of Disposition (Name of ary, crematory or other place)	une 15.	. Location - City or Town, State
Itim			`4 □ Donation 5 □ Other (Specify) Mt. U:	SK COMOTORY	004 Mi	tchellville, MD
Ba	permit. Departr Imports any inju		Sta 6 5: H MONSHO	6633 Old Alexanr	LeeFuneral	Home, Inc. ad Clinton, MD20735
			23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.			Approximate
	Physician	8	Immediate Cause (Final disease or condition	C ARREST	•	Interval Between Onset and Death
	/Medical Examiner		resulting in death) a Due to (or as a consequence			
	- Adminier	-	Sequentially list conditions fany, leading to immediate b. Due to (or as a consequence	of): CARDIO	MYOPAI	744
	rted nsit	nlne	Cause (Disease or injury	ot):		
Ć.	execuin and	Examin	that initiated events resulting in death) Last C. Due to (or as a consequence	of):		
68760,	ificate be executed g physician and is the burial-transit	edical	d			
	± 00 g	Med	IF FEMALE:	-		
.O. Box	The law requires that the death certif the has been signed by the attending age 2 should be detached for use a	Physiclan/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 1	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
S, P	res tha igned I be det	by P	Part If. Other significant conditions contributing to death but not resulting it		23e. Did tobacc	to use contribute to the cause of death?
ord	w requir been si should		PACEMAKER IMPL	MYTHON	1 Tes	2 No 3 Probably 4 Dunknown
Vital Record	e taw has b	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
					performed?	
Ξ	ysiclen: is certific director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🛣 No Hospital: 1 ☐ Inpatient 2 ☐ FR/O	0.4	Death (Check only one)	
of		-	27. Manner of Death 28a. Date of Injury 28b.	Time of 28c. Injury at	ng Home 5 X Pesidence 28d. Describe how in	
ion	arth. or: After ne funer	atlo	1 XNatural 5 □ Pending (Month, Day Year) I 2 □ Accident investigation	njury Work? M 1 ☐ Yes 2 ☐ No		
Division	or Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number,
Ω	s Hospital or Attendi 24 hours after death 9 Funerel Director: A stely filled in by the fr		20.0.0.0			
	B Hos 24 hc B Fun etely i	edical	29a. Certifier (Check only one) 1 Medical Examiner: On the basis of examination an and manner stated.	 death occurred at the time, date and plead or investigation, in my opinion, death of 	lace, and due to the cause occurred at the time, date a	(s) and manner as stated. Ind place, and due to the cause(s)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Me	29b. Signature and tipe of gettiner	29c. License number	29d. D	Date signed (Month, Day, Year)
			/ (Illes !: Kolomo	My D 2926	05 6	114/04
2	RIN	İ	3 ame and address of person who completed cause of death (Item 23a)	(Type, Print)	,	1. 11 - 1
7	DU		21 Date filed (Month Day York) 21 Date filed (Month Day York)	7501 Surratts Roa	nd Suite 303	Clinton, MD20735
	Sta Registr		31. Date filed (Month, Day, Year) 2. Registrar's Signature	books		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 09 2004 6:35 P M JUNE LILLIAN LORETTA WOODSON 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) HARFORD HAVRE DE GRACE 138 VANCHERIE COURT Birthplace (State or Foreign Country)
 Maryland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct 9, 1949 7. Age (In vrs. last birthday) 5. Social Security Number 6 Sex Days Hours 1 ☐ M 2 💢 F 54 142-42-6388 Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Havre de Grace Harford Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21078 138 Vancherie Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Specify: Black 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Housekeeping Hospital 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mary E. Christy James C. Woodson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 138 Vancherie Court, havre de Grace, MD 21078 Mary Woodson / mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State R.A. Ferris & Co. Inc 6/17/04 West Chester, PA 4 ☐Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Lisa Scott Funeral Home, P.A.
552 Lewis Street, Havre de Grace, MD 21078 21. Signature of Funeral Service Licensee JOST 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) e to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but-not resulting 1 Yes 2 10 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2□ No 2 GNO 1 Yes 26. Place of Death Check on one 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 1 esidence 6 Other (Specify) 1 Yes 2 No 3□ DOA 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide 1 Coertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D-15994 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 625 S. UNION AVE. Havre de Grace Mel. S. GALVEZ LETTELA M.D

Examiner or Attending Physiclan: The law requires that the death certificate be executed the burial-transi and nding physicien Box 68760 0 cate has been signed by the page 2 should be detached Division of Vital Records, P. certificate SIL funeral After death. within 24 hours after deatl To the Funeral Director: filled in by the Hospitel 0

Physician

/Medical

Examiner

Funeral

Director

rai', or items 23a or 28a-f show Examiner must be cutilied at

"natural"

127 is marked other than "traumatic event"

Department of Health a Important: If item 27 is eny injury or other trai once.

Physician

/Medical

the Medical

Baltimore, Maryland 21215-0036

Directo

by Funeral

Completed

Be

2

Examiner

Completed by Physician/Medical

Be

Certification: To

Medical

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) JUN 1 4 2004

32. Registrar's Signature

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Clayton Warren Wanzer June 9, /Medical 2004 5:55 A 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 1**X** M 2□ F Yrs Director 83 215 14 7350 April 6, 1921 Maryland Usual Residence of Decedent death with the Manyland 10b. County 10c. City, Town or Location ns 23a or 28a-f show 10d. Inside City Limits Completed by Funeral Director Maryland Anne Arundel Yes 2 No Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 621 Bywater Road 21401 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) the Medical Examiner lited within 72 hours after 1X Never Married 2 Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes X No Specify: 3 Widowed 4 Divorced natural **Black** 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Automobile Sales Sales traumatic avent. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fit Health and Mental H tem 27 is marked ott Be George W. Wanzer, Sr. Susie Saunders 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21084 19a. Informant's Name/Relationship (Type, Print) item 27 i Shirley Tittle/Niece 3846 Old Federal Hill Road, Jarrettsville, Maryland othar t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State to # 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ŏ permit. Page Department of Important: If any injury or once. `4 ☐ Donation 5 ☐ Other (Specify) Mount Carmel Cemetery June 12,2004 North East, Maryland 21. Signature of uneral service Liven 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland 21901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on set line. Approximate Interval Between inset and Dept Immediate Cause (Final Neymand a Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ģ should be 1 ☐ Yes 2 ☐ No 3 🗌 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? (es 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 atient Certification: To 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending after death. death. 2 Accident investigation 1 ☐ Yes 2 ☐ No the 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funerel L 29a. Certifie 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and trie of certifier 29d. Date signed (Month, Day, Year) 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JUN 1 1 2004

			1 - For State Registrar	State of Maryl		artment rtificate			d Mental	Hygier		1.0	00001
* * *	169		1. Decedent's Name (First, Middle, Last,)						of Death	201	14	9. Time of Death
	Physic /Medi		Sandra	Harle	ne	1	Wagn	er	June		^{Оау} 7 2	Year 004	11:45A M
	Exami		4a. Facility Name (If not institution, give Manor Health Car	street and number) e of Betheso	da	4b. City, T		Location of De	eath		4c. County Mon	of Death	
*	Funeral Director		5. Social Security Number 306-38-5229 Usual Residence of Decedent	7. Age (In)	vrs. last birthday) Yrs.	If Under Months	1 Year Days	If Under 24 H Hours M		h. Day, Yea	1937	9. Birthi Cour I11	place (State or Foreign ntry) inois
9003	be filed within 72 hours after death with the Maryland tal Hygiene. Identities a construction of terms 23e or 28e-f show other than "natural", or items 23e or 28e-f show event, tra Medical Evanties round be routified at	ed by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 🖫 Widowed 4 ☐ Divorced	t 12. Was Decedent Ever in Armed Forces? 1 □ Yes, Give Year or Dates:		pring 10f. Zip (Was Decede f Yes, specif	2090 ent of His fy Cubar	spanic Origin? n, Mexican, Pu Specify:	(Specify Yes o	or No-	Specify:	d St - Americ c, White,	ates can Indian, etc. Lte
Baltimore, Maryland 21215-0036	d within 72 giene. or then "net the Medici	Completed by	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual kind of work DO NOT use Cator	Occupa k done di e retired)	tion uring most of v	vorking		Kind of Bus Publi		
yland	12 should be filed within n and Mental Hygiene. 7 Is marked other than "raumatic event, the Mes	To Be C	17. Father's Name (First, Middle, Last) Vern Ch	amness				Heler		iddle, Maid Lui	en Sumame Se	e)	Auton
, Mar	and 2 sho salth and n 27 Is m		19a. Informant's Name/Relationship (Ty Victor Cham		19b. Mailin 3801	g Address (Kueb]	Street a	nd Numberor Road, I	Rural Route N Lvansvi	umber, City 11e,	or Town, S IN 47	State, <i>Zip</i> 720	Code)
imore	permit. Pages 1 and 2 should by Department of Health and Menta Importent: If Item 27 Is marked any injury or other traumatic a once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)		b. Place of Dispo cemetery, cren Hill Ci	natory or oth	e of her place	Jun	Date e 22,20	W.	Location - C Carter	•	wn, State Le, IL
Balt	permit. Departi Import any inj		21. Signature of Juneral Service Cicense	Jugar 1	22	Name and Rapp 933	Address Fune Gist	of Facility Eral An Avenue	d Crema Silve	ation r Spr	Servi	ices MD 2	20910
8760,	Physician // / / / / / / / / / / / / / / / / /	il Examiner	23a Part Sette the disease, or compli- shock, or freart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underly in Cause (Disease or injury that initiated events resulting in death) Last	Colon Can Due to (or as a cons Metastasi Due to (or as a cons Colostomy	acer sequence of): .s to Liv sequence of):	ver	of dying	, such as card	ac or respirato	ory arrest,			Approximate Interval Between Onset and Death
.O. Box 687	death certific e attending p od for use as	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pred 1 Live birth 2 F 4 Pregnant at time of 9 Unknown	gnancy etal death 3 🗆	Ectopic pred					23d. Date Mont		ry Day Year
S, D	sign sign d be	by	Part II. Other significant conditions con	tributing to death but not i	resulting in the un	derlying cau	ise giver	n in Part I.					e cause of death?
of Vital Record	The law ate has b page 2 si	Completed							a	Mas an autopsy performed? es 2⊠N	pri de	or to con ath?	osy findings available apletion of cause of 21/2 No
<u> </u>	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:					eath (Check or				
	ding h. After fune	tion: To	1 Yes 2 No 27. Manner of Death 1 XNatural 5 Pending 2 Accident Investigation	1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury		c. Injury a Work?	at wursing	Home 5 F		6 Other)
É	in Qife	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - Al building, etc. (Spe	t home, farm, stre	et, factory,			28f. Locatio City or	on (Street a Town, Sta	ind Number te)	or Rural	Route Number,
	Fu P P	edicai	29a. Certifier 1⊠ Certifying Phys (Check only one) 1☑ Medical Examin	ician: To the best of my ker: On the basis of exami and manner stated.	knowledge, death ination and/or inv	occurred at estigation, in	the time	, date and plac nion, death occ	ce, and due to curred at the time	the cause(me, date ar	s) and manr nd place, an	ner as sta d due to	ited. the cause(s)
)	To the within 2 To the complet	Σ	29b. Signature and title of certifier	Ofre 1	M.D		License i				ate signed (Month, E	
			30. Name and address of person who con Kirti Vohra M.D.	npleted cause of death (It			hesd	la, MD	20817				
3	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sig	// 4	doa	Ms	,					

			1 - State Registrar	State of Maryland		artment of H rtificate of L			ene g. No2 N N L	20065
			1. Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
	Physicia /Medic		Pearl Elizabeth					June 9	2004	10:20 ам
1	Examin	er	4a. Facility Name (If not institution, give :			4b. City, Town, or		th	4c. County of Dea	
	Funeral		Hillhaven Nursir 5. Social Security Number 6. Sex	7. Age (In yrs. I		Adel] If Under 1 Year Months Days			Prince G	eorge's thplace (State or Foreign ountry)
L	Director		Z1/-36-5/54	M 2 □ X F 97	Yrs.	Months Days	Tiodis	Jan. 6,		orgia
	land ow	}	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	ocation				10d. Inside City Limits
	Mary B-f sh	ctor	Maryland Prince G	George's Uni	versit	y Park				1 ☐ Yes 2 🃉 No
	or 28	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?
	eath v		6705 40th Avenue	12. Was Decedent Ever in U.	S 13	20782	isnanie Origin? (Specify Yes or No-	U.S.A.	erican Indian
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show amy injuryor other traumatic avent, I're Medical Evanical must be indiffied at once.	by Funerai	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 1 No	n, Mexican, Puel Specify:	to Rican, etc.)	Black, Whi	
Maryland 21215-0036	72 hou	Completed	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usual Occupa	during most of wo	orking	6b. Kind of Business	/Industry
2	within ene. than '	Jumo	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired				
2	filed Hygi other	Be Co	17. Father's Name (First, Middle, Last)	4	58	les Assoc		me (First, Middle, M.	Retail aiden Sumame)	
lar	Menta Menta arked artic av	To B	Martin Estes Fr	'ee			Marth	a Elizabe	th Blaloc	<u> </u>
Man	12 sho h and 7 is mu traum		19a. Informant's Name/Relationship (Ty Selwyn Walter/ Hu		1			ural Route Number,		Zip Code)
ē,	Healt Healt tem 2		20a. Method of Disposition	20h P	lace of Disor	eition (Name of		ttsville,	MD ZU/8Z 0c. Location - City or	Town, Stete
Baltimore,	Pages ment of ant: If i		1 ☐ Burial 2 ☐ Cremation 3 ☐ P 4 ☐ Donation 5 ☐ Other (Specify)	temoval from State	ort Li Ceme	matory or other plac ncoln tery	*/ Ji	ine 14, 2004	Exentwood,	Maryland
Balt	Departr Mports Iny inju		21. Signature of Funeral Service Licens			the provided of the fact of the	4 44 114			
S.	TOSEC		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	idations that caused the death	n. Do not eni	500 Unive	rsity Bl	c or respiratory arres	lver Sprin	g MD 20901
	Physician		shock, or heart failure. List only or Immediate Cause (Final disease or condition							Onset and Death
	/Medical		resulting in death)	Due to (or as a consequ	uence of):					5 Years
1	Examiner	9	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	uanea of):					
	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
8760,	ate be executed hysician and the burial-transit	I Exa	resulting in death) Last	Due to (or as a consequ	uence of);					
687	physik s the b	dical		d						
Box (leath certific attending pl	n/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregna 1□Live birth 2□Fetal		∃Ectopic pregnancy			23d. Date of de	livery
O. B	at the deatl by the atte	Physiclan/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 Pregnant at time of de		Other (specify)			Month	Day Year
₫.	that the	/ Phy	Part II. Other significant conditions con	ntributing to death but not resu	ulting in the u	nderlying cause give	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
rds,	es De	ed by						1 ☐ Yes	2 X No 3 □ P	robably 4 Unknown
Record	law requir as been si 2 should	Completed						24a. Was an autopsy	24b. Were as	utopsy findings available completion of cause of
<u>ج</u>		Соп						performe		2 □ No
Vital	ysician: The la is certificate has director, page 2	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 📉 No	fospital: 1 Inpatient 2	ER/Outpatier	nt 3 DOA Othe	200	ath <i>(Check only one)</i> Home 5 Residen		
J Of	Attending Physician: r death. sctor: After this certificator; by the funeral director;	\vdash	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o			28d. Describe how		eny)
sior	ttending Phy death. :tor: After this r the funeral o	catio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			M 1 🗆 '	Yes 2 □ No			
Division	after deatl	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, str /)	reet, factory, office		281. Location (Stre City or Town,	et and Number or Ri State)	ural Route Number,
	a s a a			sicien: To the best of my kno				e, and due to the cau urred at the time, dat		
	ne Hospital 24 hours ne Funeral sletely filled	ğ	(Check only 2 Medicel Exemi	and manner stated.						to the cause(s)
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical				29c. License		290	d. Date signed (Mont	``
)		Medic	29b. Signature and title of sertifier	and manner stated.)	D262			une 10, 2	h, Day, Year)
	To the Hosp within 24 hou To the Fune completely fil	Medic	one)	and manner stated. A publication of the state of the sta		D262	87		une 10, 2	h, Day, Year)

			1 - For State Registrar	State of Ma	-		nent of H		Mental Hy	giene	
	Physici /Medic		1. Decedent's Name (First, Middle, Las George We	7.1					2. Date of De Month	Day	Year 4:21 PM
	Examir		4a. Facility Name (If not institution, give	street and number)		4b.	City, Town, or	Location of Dea		4c. County	of Death
			Itabor Hospital	Center			74 11/24	ore	,	1	timore
	Funeral Director		5. Social Security Number 6. Se 207-52-7348 Usual Residence of Decedent	X 7. Ag	6 6	Yrs. If U	Inder 1 Year oths Days	If Under 24 Hr Hours Mir	8. Date of Bir (Month, Da Jan.	19, 1938	9. Birthplace (State or Foreign Country) Virginia
	land ow		10a. State 10b. County		10c. City, Tow	n or Location	1				10d. Inside City Limits
	Mary Frsh	to	MD Baltime	ore	Ва	ltimo	ore				1 🕍 Yes 2 🗀 No
	n the	Director	10e. Street and Number			101	f. Zip Code			10g. Citizen of W	/hat Country?
	23a c	al D	2131 Annapol	is Road			212	30		U.S.	Α.
99	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Machel Evarting must be routiled at once.	y Funeral	11. Marital Status 1 ☐ Never Married 2X Married	12. Was Decedent Armed Forces? 1 Yes 2411 If Yes, Give			ecedent of Hi specify Cuba	spanic Origin? (n, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)	14. Race Blace Specify:	e - American Indian, k, White, etc.
8	hours 'ural',	d by	3 Widowed 4 Divorced	Year or Dates:	1 10-	Daniel de Ma					Втаск
75	n 72	lete	15. Decedent's Ed (Specify only highest grad	de completed)		(Give kind o	Usual Occupa of work done of OT use retired	uring most of we	orking	16b. Kind of Bu	siness/Industry
21215-0036	iene r than "	Completed	Elementary/Secondary (0-12) 5th	College (1-4or 5	5+)			e Tech	1	Quali	ty Inn
	e filed Il Hygie other	Be C	17. Father's Name (First, Middle, Last)		, , , , , , , , , , , , , , , , , , , 			18. Mother's Na	ame (First, Middle	, Maiden Sumam	θ)
/lar	should be land Mental is marked o	To B	Roosevelt	Webb				Iren	ne Reio	đ	
Maryland	l 2 sho n and l is ma rauma		19a. Informant's Name/Relationship (T)						Rural Route Numb		State, Zip Code) D 21230
	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tropics.		Inez V. Webb -	wire			_		Date		City or Town, State
nor	Se in age		Murial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,		20b. Place of cemeter						own, MD
Baltimore,	artme ortan injur		21 Signature of Funeral Service Licens		Mt. Z	Nam	Jelli ne and Addres				1 Home, PA
Ba	permil Depar Impor any in	1	100003 K	Sono	rlea	246	6 N Wa	ashingt	on St	Rockvil	le,MD 20850
. 4	Pnysician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	ne cause on each fir	the death. Do not he.	. ,	mode of dying	g, such as cardia	ac or respiratory a	rrest,	Approximate Interval Between Onset and Death
1	/Medical Examiner		resulting in death)	d	a consequence		rianon				Eminutes
	Examiner	1 70	Sequentially list conditions,	b. Myoc	callul_	Data	ction				20 years
	nted Insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	AS1	1/1	017.					
ć	be executed sician and burial-transit	Еха	that initiated events resulting in death) Last	Due to (or as	a consequence	of):					
8760,	ate be ex hysician the buria	cal		d							
9	ertifica ling ph	Med	IF FEMALE:	222 14							
Box	death certificate be executed to attending physician and ed for use as the burial-transit	Physician/Medical	in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death		oic pregnancy or (specify)			23d. Date Mon	of delivery th Day Year
P.O	at the de d by the a	Phy	9 Unknown			- M			On Did		h. 4. 4. 4. 4. 4. 4. 4. 4. 4. 4. 4. 4. 4.
Records,	w requires that been signed I should be det	by	Part II. Other significant conditions co	ntributing to death bi	ut not resulting in	n the underly!	ing cause give	n in Part I.			bute to the cause of death? 3 Probably 4 Gunknown
Reco	e la has je 2	Completed							24a. Was autop perfo 1 \sum Yes	osy primed? de	/ere autopsy findings available rior to completion of cause of eath? ☐ Yes 2☐ No
Vital	sician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?					26. Place of De	ath (Check only o		
of V	X S	10	1 Yes 2 No	Hospital: 1 ☐ Inpatie	ent 2 ER/Ou	tpatient 3	DOA Othe	4 Nursing	Home 5 ☐ Resid	dence 6 □Othe	r (Specify)
O L	ing fter ine	on:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	ry 28b. T y Ye <i>ar)</i>	Time of njury	28c. Injury Work	at ?		now injury occurre	
Sio	ttendi death. stor: A / the fu	cat	2 Accident investigation 3 Suicide 6 Could not be	00- 71	415	M		′es 2□No	204 Lanation (Chana han d Aleen te	
Division	l or Ai after d Direct	Certification:	4 Homicide determined	28e. Place of Inju building, etc	c. (Specify)	ırm, street, ta	стогу, опісе		City or Tov	vn, State)	r or Rural Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical C	29a. Certifier 1 Certifying Phy (Check only one)	rsician: To the best of the state of the basis of and manner state of the basis of	examination and	dor investiga	rred at the tim ation, in my op	e, date and plac inion, death occ	e, and due to the urred at the time,	cause(s) and man date and place, a	ner as stated. nd due to the cause(s)
	To th within To th	Me	29b. Signature and title of pertifier	1	1		29c. License	number		29d. Date signed	(Month, Day, Year)
	7		> Noture m Ch	ugnych	MA		D005	2022		JUNE 8	, 2004
	(30. Name and address of person who co Robert M Yaco	ompleted cause of d	eath (Item 23a)	Type, Print)	spital C	conter, 15	Balhmere,	Maryland	(Month, Day, Year) 7, 2004 21225
	Sta Registr		31. Date filed (Month, Day, Year) JUN 11 20	32. Registra	ar's Signature	9 4	parks	/			

			1 - For S	tate of Mar	yland / Depa <i>Cer</i>	artment of H			giene Reg. NG. () ()	1. 20067
	Physici	an	Decedent's Name (First, Middle, Last)	4.60	White	•		2. Date of Dea Month	ath Day	Year
	/Medic	al	Lawre 4a. Facility Name (If not institution, give street		VVIVICE		r Location of Death	Tune	4c. County o	004 0620 AM
1	Examin	er		3 eneral	Hospital	Col	umbia			vard
	Funeral Director		5. Social Security Number 6. Sex 1 図 M	7. Age (In yrs. last birthday).	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day 7-17-2	h y, Year)	Birthplace (State or Foreign Country) Ohio
	pur &		Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town or Lo	cation				10d. Inside City Limits
	Maryle f shor	īo	MD Montgomer		Silver Sp					1 ☐ Yes 2 ☑ No
	death with the Maryland ims 23a or 28a-f show russt be notfilled at	lrec	10e. Street and Number		Darver by	10f. Zip Code			10g. Citizen of W	hat Country?
	ath wil	ral	10604 Lilac Pl.			209			U.S.A.	·
98	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic avent, the Medical Extinction must be notified at ance.	by Funeral Director	1 Never Married 2 Married	Was Decedent Event Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates:	er in U.S. 13. V	Vas Decedent of H Yes, specify Cuba ☐ Yes 2 ☑ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	14. Race Black Specify:	- American Indian, ; White, etc.
21215-0036	2 hou	ted	15. Decedent's Education	on	16a. Deced	ent's Usual Occup	ation	king	16b. Kind of Bus	White iness/Industry
218	ithin 7 ne.	Completed		College (1-4or 5+)	life. L	OO NOT use retired	during most of world	ang		
121	Hygier thar th	S	12 17. Father's Name (First, Middle, Last)		Ana	lyst	18. Mother's Nam	ne (First, Middle,	Fed. G	
Maryland	d 2 should be filed within h and Mental Hygiene. 7 Is marked other than "reaumatic avent, the Men	To Be	Algar E. White				Elva Sca			,
lary	2 should and Mils mail		19a. Informant's Name/Relationship (Type,		1	•	and Number or Rui			
-	1 and Health sm 27 thar tr		Jeanne Isrin - Daug	hter			Ave. Silv	ver Spri		0901 City or Town, State
Baltimore,	gor of grades		1 🛱 Burial 2 ☐ Cremation 3 ☐ Remi '4 ☐ Donation 5 ☐ Other (Specify)	oval from State	20b. Place of Dispose cemetery, crem Parklawn		1		Rockvill	
altii	permit. F Departme Importar any injur		21. Signature of Funeral Service Licensee	1			ss of Facility Hi			
8	88 2 2 8		Duam a.	offile						ring, MD 20904
	Physician		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one of timmediate Cause (Final disease or condition		e deeth. Do not entered to the consequence of):		ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a c	consequence of):	Track	in ha	hien		P
		Jer	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a r	inary consequence d): adder	Traci	Inter	7.0.7		
	be executed ician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			Ca	ncer			
8760,	icate be exe physician a s the burial-	al Ex	resulting in death) Last	Due to (or as a c	consequence of):					
687	ificate g phys as the	edical	d							
Box	eath certific attending pl	an/M	23b. was decedent pregnant	If yes, outcome of 1□Live birth 2		Ectopic pregnancy	<i>,</i>	/A	23d. Date Mont	-
P.O. E	that the death ed by the atte detached for	Physician/Me		4□Pregnant at tin 9□Unknown	ne of death 5	Other (specify) _			IVIORI	N /A
ls, P.	es De d		Part II. Other significant conditions contrib		not resulting in the ur	nderlying cause giv	en in Part I.	23e. Did to		oute to the cause of death?
cor	w requir been s should	letec			-ailure			24a. Was	^	
Re	sician: The law s certificate has t lirector, page 2 s	Completed by	0011					autop	rmeg// de	ere autopsy findings available for to completion of cause of eath?
/ital	cian: ertifica ector, p	Bec	25. Was case referred to medical examiner?				26. Place of Deal			
of	Phy this	٦.	1 ☐ Yes 2 No Hosp	1 Launpatient			4 🖂 ivuising m		dence 6 Other	
ion	nding F ath. r: After e funera	atlon	1 Natural 5 Pending investigation	8a. Date of Injury (Month, Day Y	/ear) Injury	28c. Injur Wor M 1 🗆	k? Yes 2 □ No		,.,	
Division of Vital Records,	al or Atta s after des l Diractor d in by the	Certification;	3 Suicide 6 Could not be 4 Homicide determined	8e. Place of Injury building, etc.	r - At home, farm, stre (Specify)	eet, factory, office		28f. Location (S City or Tow		r or Rural Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical C	29a. Certifier (Check only one)	en: To the best of e On the basis of eand manner state	xamination and/or inv	occurred at the tir restigation, in my o	ne, date and place, pinion, death occur	and due to the orred at the time, o	cause(s) and mand date and place, an	ner as stated. Indicated the cause(s)
	To the To the comp	M	29b. Signature and title of certifier	m	M.D.	29c. Licens	5653	3)	Tune	(Month, Day, Year)
	17		30. Name and address of person who comp	leted cause of dea		Print)	0-01	Cali	mbia	mD21044
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's	Hickory s Signature	Mage	(Lours	Colu		111121077
	Registi		JUN 1 0 2004	Sener	pa B	spark				

			1 - For State Registrer	State of Ma		d / Depa	artment	of Health a	and Me	ental Hy		004	20068
	Physici /Medic		1. Decedent's Name (First, Middle Rodney Lee	Williams					2	2. Date of De Month June	Day 2	2004	3. Time of Death 9:35A M
	Examir		4a. Facility Name (If not institution Shady Grove Ad 5. Social Security Number	ventist Hosp		ast birthday)	· .	own, or Location of Ville Year If Under:		Date of Bi	Mon	tgomer	У
	Funeral Director		217-70-4517 Usual Residence of Decedent	1X M 2 F	46	Yrs.	Months	Days Hours	Min.	B. Date of Bir (Month, Da Aug 4,	ay, Year)	9. Birti Coi Ma:	nplace (State or Foreign Intry) ryland
ie Marylan	Be-f show	ctor	Maryland Montg	omery		, Town or Lo							10d. Inside City Limits 1 X Yes 2 □ No
th with th	23e or 2	al Dire	10e. Street and Number 17650 Kohlhoss	Road			10f. Zip C	ode 0837				n of What Cou d State	•
:1215-0036 within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: If item 23e or 28e-1 show Important: If item 27 is marked other then "natural", or Items 23e or 28e-1 show any injury or other traumatic event, the Modical Examinations in the notified all once.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:			Was Deceder f Yes, specifi 1 ☐ Yes 2	nt of Hispanic Origy Cuban, Mexican No Specify:		ify Yes or No ican, etc.)		. Race - Amer Black, White pecify: Bla	, etc.
21215-0036 od within 72 hours aft	giene. er then "natur ifte Madical	completed	15. Decedent (Specify only highes Elementary/Secondary (0-12) 12	's Education it grade completed) College (1-4or 5	+)	(Gîve life. L	DO NOT use	done during most		7	Mon	of Business/l tgomery ools	ndustry y County
Maryland 3 nd 2 should be file	d Mental Hyg narked othe natic event,	To Be C	17. Father's Name (First, Middle, Roger Eugene 19a. Informant's Name/Relations!	Williams		10h Mailie	Address (Lil	Lly N	First, Middle	У		
, Ma and 2 sl	ealth an n 27 is r ner traur		Shirley M. W	illiams (Wif		17650	Kohlh	Street and Numbe	l-Pool	Lesvil	le, M	aryland	1 20837
Baltimore,	lant: If iter jury or oth		20a. Method of Disposition 1 ☐ Burial 2 【 Cremation 4 ☐ Donation 5 ☐ Other (S)	pecify)			tan Cr	ematory	June 2004		Alexa		own, State Virginia
Ball Permit	Depar Impor any in		21. Signature of Funeral Service	Lyver)			Address of Facility					irg, MD 2087
E)	physician and Medical sthe prinal-transit	ical Examiner	23a. Pant. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	only one cause on each lin	cereb a consequ osis	eral He			cardiac or r	respiratory a	rrest,		Approximate Interval Between Onset and Death 24 Hours
I Records, P.O. Box 68760, The law requires that the death certificate be executed	red by the attending phy: detached to use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at	2 Fetal	death 3	Ectopic preg				230	d. Date of deliv	rery Day Year
rds, P.	5 0	by	Part II. Other significant condition	ns contributing to death bu	ut not resu	Ilting in the ur	nderlying cau	se given in Part I.					the cause of death?
al Records,	icate has been si r, page 2 should I	Completed								24a. Was autor perfo 1 - Yes	rmed?		opsy findings available ompletion of cause of
on of Vital	n. After this certiticate has tuneral director, page 2	tlon; To Be	25. Was case referred to medical examiner? 1 Yes No 27. Manner of Death 1 Natural 5 Pendin 2 Accident investig		v	ER/Outpatient 28b. Time of Injury		Other	rsing Home	Check onl of 5 Residence I	dence 6	Other (Speci	fy)
Division al or Attending	s after death. Il Director: After t od in by the tunera	Certification;	2 Accident investig 3 Suicide 6 Could r 4 Homicide determi	not be 200 Place of Injur	ıry - At ho :. (Specify	me, farm, stre				f. Location (S City or Tox		lumber or Run	al Route Number,
Diy To the Hospital or	within 24 hours a To the Funerel (completely filled	Medical C	one)	g Physicien: To the best of examiner: On the basis of and manner sta	of my knov examinati	vledge, death ion and/or inv			d place, and th occurred				
To	To	2	29b. Signature and title of confier			AM	D	icense number 58681			_	, 2004	Day, Year)
	15	i i	30. Name and address of person Jude Alexande					Drive -	- Rock	ville	, Mar	yland 2	.0850
	Sta Registr		31. Date filed (Month, Day, Year) JUN 0 7	2004 32. Registra	ar's Signat	ure £	Spa	els					

			For State					nd Mental Hy	giene			
			1. Decedent's Name (First, Middle, Last	5 PER FH	G832 6/25	Milicate or	Death	2. Date of De	Reg. No.	2 Time of Death		
	Physici /Medi		NORMAN FLOYD WIMS Day Year Month Da									
3	Examin	er	4a. Facility Name (If not institution, give Shady Grove Ac	· ·	Hogni + a	4b. City, Town,	or Location of C		4c. County of			
	Funeral		525pcpal 33cquity()Ygrqt5pr 6. Se		(In yrs. last birthday) If Under 1 Year	If Under 24	Hrs. 8 Date of Bir	th a	GOMERY Birthplace (State or Foreign Country)		
	Director		217 30 9611	X M 2□ F	69 Yrs.	Months Days	Hours	Min. Aug. 1.	2,1934	Maryland		
	and		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or L	ocation				10d. Inside City Limits		
	Marylan -f show find at	tor	MD Montg	omery	Gai	thersbu	ırg			1X Yes 2 □ No		
	or 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	at Country?		
	s 23e		14 O'Neill				20877			.A.		
21215-0036	within 72 hours after death with the Maryland ene. than "neturel", or Items 23e or 28e-f show the Medical Evar in art must be rediffed at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 14 Yes 2 N If Yes, Give Year or Dates:	10	Was Decedent of If Yes, specify Cult		n? (Specify Yes or No Puerto Rican, etc.)		American Indian, White, etc. Black		
5-0	netur	To Be Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) (Cive kind of work done during most of working life. DO NOT use retired)							ess/Industry		
121	within ane. then		Elementary/Secondary (0-12)	+)			,	010101				
d 2	s 1 and 2 should be filed within 7 f Health and Mental Hygiene. Item 27 Is marked other then "n other treumatic event, Item Act		12th Receptionist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last)						Gaithersburg			
Maryland			Earl Wims, Sr. Rachel A.							,		
Mar	d 2 sh th and t7 Is m treum		19a. Informant's Name/Relationship (T) Mildred Wims					or Rural Route Numbe		te, Zip Code) , OR 97211		
	s 1 and 2 of Health Item 27 I	1	20a. Method of Disposition		20b. Place of Disp			Date	20c. Location - City			
<u>E</u>	Page nent o		XXBurial 2 ☐ Cremation 3 ☐ F '4 ☐ Ponation 5 ☐ Other (Specify)					6/24/04	Ft. My	er,VA		
Baltimore,	permit. Pages 1 Department of He Importent: If Iter any injury or oth		21. Signatur of Funeral Service Livens	Shou	deu 12	2. Name and Addr	ess of Facility	SNOWDEN St., Rock	FUNERAL	HOME, PA. MD 20850		
	Physician		23a. Part1. Enter the disease, or complications that caused the death. In not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Caused Final Programme Pr									
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):							
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Council (Lisease or Injury)	b. Due to (or as a	a consequence of):							
,0928	cate be executed physician and the burial-transit	dicai Exa	that initiated events resulting in death) Last	Due to (or as a	a consequence of):							
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P.O. Box	requires that the death certifit been signed by the attending f hould be detached for use as	To Be Completed by	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown						23d. Date of delivery Month Day Year		
	s that ned b		Part II. Other significant conditions con	ntributing to death bu	it not resulting in the	underlying cause gr	ven in Part I.	23e. Did to	bacco use contribut	te to the cause of death?		
ords	e faw has b		Congestive Heart Failure 10 Yes						′es 2. V No 3.[2 No 3 ☐ Probably 4 ☐ Unknown		
Division of Vital Records,			<u> </u>					24a. Was autop perfor	sy prior med? deat			
ita	icien: Th		25. Was case referred to medical				26. Place of	1 ☐ Yes Death (Check only of		Yes 2□ No		
> >	ys dir		examiner? 1 \sum Yes 2 No	lospital: 1 Inpatie	nt 2 ER/Outpatie	nt 3 DOA	her: 4 🗌 Nursir	ng Home 5 Resid	ence 6 Other (S	Specify)		
S C	ng ftei		27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28d. Describe how injury occurred									
isio	Attending r death. sctor: After by the fune	ficat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e Place of Init	rry - At home, farm, st]Yes 2□No		Street and Number o	r Rural Route Number,		
Οį	rs after el Dire	Certification;	4 Homicide determined	building, etc	(Specify)	rest, factory, office		City or Tow	n, State)	Transfer Toute Number,		
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
			29b. Signature and title of certifier	, 11		29c. Licen:			29d. Date signed (M			
			Custinfai	her Hou	ue mo	Do	0598	71	May 30	2004		
_	10		30. Name and address of person who co	Howe n	ath (Item 23a) (Type	Print) Ol Medic	cal Cen	iter Dr. ve	Rockvil	la Maryland		
	Sta Begistr		31. Date filed (Month, Day, Year)	32. Registra	r's Signature	Sports						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year **Physician** Margaret Louise Younkins 0746 AM mu /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hagerstown Washington County Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 2XF Days Hours 82 Director Vrs 1921 Maryland 213-12-7275 Usual Residence of Decedent the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28e-f show id 2 should be filed within 72 hours after death with the Maryla th and Mantal Hygnene. 27 is marked other then "naturel", or Items 23a or 28e-f shov treumatic event, "the Macifed Eme" in serious Le mullised at Washingotn Hagerstown 1 Yes 2 No Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21742 12038 Warrenfeltz Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 Nidowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NDT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Personal Residence Homemaker 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Irene Kline Allison Bowers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it Pages 1 and 2 shurthent of Health and 12038 Warrenfeltz Lane Hagerstown, Maryland 21742 Alice I. Younkins /Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

✓ Burial 2 ☐ Cremation 3 ☐ Removal from State Cedarlawn Memorial Park June 2 Hagerstown, Maryland in ury ' 4 ☐ Donation 5 ☐ Other (Specify) Departr Departr Importa any in 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licen M/139J 1331Eastern Blvd. N. Hagerstown, Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) ardiore Physician /Medical Due to (or as a Examiner Cause (Disease or injury that initiated events Examiner ed by the attending physician and detached for use as the burial-transit certificate be executed resulting in death) Last P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗌 Yes 2500 1 🗌 Yes 25. Was case referred to medical 26. Place of Death Check onl one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🐼 No 1 ☐ Inpatient 2 ☐ FN/Outpatient 3 ☐ DOA Certification: To SIL 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred after death. Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation Accident Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C Hospitel 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1/22 State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** /Medical 4b. City, Town, or Location of Death 4a. Facility Neme (If not institution, give street and number) **Examiner** OWSON 05 1Ca1 7. Age (In yrs. last birthday)
Yrs. If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, DeC. 24 5. Social Security Number **Funeral** Months -686 1-16-Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at once. 1 □ Yes 20 No Directo Imonium 10f. Zip Code 10g. Citizen of What Country? Be Completed by Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1 by Yes 2 □ No W, W, II I'Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2 ame (First Middle Maiden Sumame) 17. Father's Name (First, Middle, Last) 2 (D) Ug 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Winell Timonium 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Evans Funeral Chapel Boldy * 4 □Donation 5 Other (Specify) 25,200 21. Signature of Funeral Service Licensee tives funeralt fer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sudden cardin duth **Physician** /Medical Examiner 20 YAS Cormany arting disease Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to (or as a consquence of) by Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 | Fetal death 1 ☐ Live birth in the past 12 months?
1 Yes 2 No Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Escented hyporthumin 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 1 ☐ Yes 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2. ER/Outpatient 3 ☐ DOA Other: Medical Certification: To 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) this 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Yeer) 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 Yes 2 No within 24 hours after death. To the Funerel Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier ī Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) D 026575 06-22-2004 30. Name and address of person who mpleted cause of death (Item 23a) (Type, Print) 10155 YORK RD DAVID J. HARTIG, M.D. COCKEYSVILLE, MA 21030 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 2 5 2004 Registrar

740	01		For State Registrar	Sta	ate of Maryla		artment of h		d Mental H	lygien	2001	200	70
			Decedent's Name (First, I	Middle, Last)			timouto or	Dout	2. Date of		0.004	3, Time	of Death
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	Examir	er		-					pall!		· ·	am	
			Johns Hopkin 5. Social Security Number	6. Sex		s. last birthday)	If Under 1 Year	timore	Hrs. I 8 Date of	Birth	N/A	irthologo /State	or Foreign
	Funeral Director		215- ALL-114	1 1 X M 2		Yrs.	Months Days		lin. (Month,		582 1	irthplace (State Country)	or Foreign
			Usual Residence of Decede	nt —					DEPT	04:17	100	MIZYZ	MUL
	Maryland -1 show		10a. State 10b. Co	ounty	10c.	City, Town or Lo	cation					10d. Inside	City Limits
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	death	Funeral	11. Marital Status	12. W	as Decedent Ever in		Vas Decedent of H f Yes, specify Cuba	dispanic Origin?	(Specify Yes or	No-		nerican Indian,	
(0	or Ite		1 Never Married 2□	Married 1	med Forces? □Yes 2 28 No				Jerto Rican, etc.)		Black, Wh	nite, etc.	
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Maryland	0 00		19a. Informant's Name/Rela	tionship (Type, P	rint)	19b. Mailir	g Address (Street	and Number or	Rural Route Nui	mber, City	or Town, State,	Zip Code)	
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altimore,		li i	20a. Method of Disposition			. Place of Dispo	sition (Name of natory or other place	ce)	Dale	200.1	ocation - City o		
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			shock, or heart failure. Immediate Cause (Final	List only one cau	ise on each line.	0.00	.001.		0.			Interval Be Onset and	
	/Medical	0.1	disease or condition resulting in death)	a. V F	Due to (or as cons	Gun	suut v	vou				-	
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€C	elaw hasl	idπ				-			24a. W	as an itopsy informed?	24b. Were a	utopsy findings completion of	available cause of
The latter of th							1 Yes					s 2 No	
Zi Zi	Attending Physician: r death. sctor: After this certifics by the funeral director, t	To Be	25. Was case referred to me examiner?	edical Hospita	al:		Oah		Death (Check on				
of	Phys this al dir		1 XYes 2 No		i 🗆 inpatient 💪	K ER/Outpatien		4 IAMISIII	gHome 5□Re			ecify)	
L C	ding I	ion:			a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describ	e now inju	d VIO	at	
Sio	tend leath tor: /	cat	2 - 100100111	vestigation ould not be	6-20-04	Felina 6:2		Yes 2 No	146	ecere	CX WELL	<i>)</i>	
\leq	or At after d Direct in by	III.	4 Homicide	etermined 28	 Place of Injury - At building, etc. (Spe 	cify)	eet, factory, office		28t. Location City or	n (Street al Town, State	nd Number or E	Perlman	nber /
	rs al	Ce			car		tricer		tatti	will	City &	10	
	Hospital 44 hours a Funeral I	icai	(Check only 2 - Mei	dical Examiner: C	: To the best of my k on the basis of exami	nowledge, death nation and/or inv	occurred at the ting estigation, in my of	ne, date and pla pinion, death o	ace, and due to the courred at the time	ne cause(s le, date an) and manner a diplace, and du	s stated. e to the cause(s)
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Certification:	one) A	1	rid manniar stated								
	To To		29b. Signature and title of		1.	11	29c. Licenso	o.C.M.	ਸ		ite signed (Mon $e~21$, $~2$	-	
	0		1/10	N	V /	VI		O.C.M.	ه ند	Jun	e 21, 2	.004	
	3		30. Name and address of pe									603	
_			5.12.1-	1061A	N	11:	Penn St	reet, E	Baltimor	e, Ma	ryland	21201	
	Sta		31. Date filed (Month, Day, JUN 2 5	2004	32. Registrar's	nature	9						
	Regist	ar	U CIT A D	LOUT Ju							411		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death June 22, 2004 **Physician** Year Selma Clara Ahrenberg 4:50 p. м /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HCR Manor Care Dulaney Baltimore Towson 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Yeer) 10/20/1903 Birthplace (State or Foreign Country) Social Security Number **Funeral** 217 36 3041 1 □ M 2 💢 F 100 Yrs. Director Maryland Usual Residence of Decedent 10c. City, Town or Location Baltimore the Maryland 10b. County 10a State 10d. Inside City Limits r then "naturel", or items 23s or 28s-f show the Medical Examinar must be notified at n/a Yes 2 □ No Director 6225 York Rd. Apt. 318 10f. Zip Code 10g. Citizen of What Country? 21212 USA Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11 Marital Status I □Yes 2∑No IYes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2♥ No Specify: White ₽ 3XXVidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 6 other 1 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked other any injury or other traumatic event 9088. Charles Werneth Augusta UNK 19a. Informant's Name/Relationship (Type, Print) GRAND-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ahrenberg DAUGHTER-IN-LAW 7825 Ridgely Oak Rd. Parkville Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Moreland Mem. Park 6/25/04 Parkville, MD. 21. Signature of Foneral Service Licensee 22. Name and Address of Facility Cvach/ROsedale Funeral
1211 Chesaco Avenue Rosedale Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ALUTE MYUCARMIAL **Physician** INFARC TION 2 HX /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospitel or Attending Physicien: The law requires that the death certificate be execute Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed: 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No is after deam.
rel Director. After this ceruina.
rel by the funeral director, pe 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 27. Mannes of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 T Homicide within 24 hours a To the Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 4 Jahs JUNE 23 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Townard un uns 7505 OSICA PHIVE MARIS 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

JUN 2 5 2004

			For State Registrar	State of Maryland		irtment of H <i>tificate of I</i>		•	giene	1001	20076	
			Decedent's Name (First, Middle, Last)			4.		2. Date of De	5016		3. Time of Death	
9	Physicia /Medic		Charles E.	Bromelow				06	Q)	2034	6:458 M	
	Examin		4a. Fecility Name (If not institution, give s	4		4b. City, Town, or			1 .	County of Death		
3			Carroll Hospita			Westmin				aroll C		
	Funeral		5. Social Security Number 5. Sex	7. Age (In yrs. Is	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Min	(Month Da	v. Year)	9. Birthp	ace (Stete or Foreign try)	
	Director	-	235-24-6042 Usual Residence of Decedent	81	113.	Jan. 25, 1923 West Virgini						
	land ow	Ì	10a. State 10b. County	10c. City	, Town or Lo	cation				1	0d. Inside City Limits	
	Many Fish	ō	MD Carroll	Syk	esvill	e					1 ☐ Yes 2 No	
	or 28g	Director	10e. Street and Number			10f. Zip Code			10g. Citi	zen of What Cour	try?	
	th will	a	5800 Formosa Drive			21784			Unit	ed State	S	
	r dea	nei	11. Marital Status	2. Was Decedent Ever in U.S Armed Forces?	6. 13. V	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (In, Mexican, Pue	Specify Yes or No into Rican, etc.)		 Race - Americ Black, White, 		
36	within 72 hours after death with the Maryland one. Than "natural", or items 28a or 28a-f show the Medical Examiner must be notified at	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give 1943 Year or Dates: 1943	_	☐ Yes 2🌠 No	Specify:			Specify: Wh	ite	
21215-0036	hour	edt	15. Decedent's Educ	1946	16a, Deced	lent's Usual Occup	ation		16b. Kir	nd of Business/Inc	lustry	
15	n 72 n "na Medic	Completed	(Specify only highest grade Elementary/Secondary (0-12)		(Give	kind of work done of OO NOT use retired	during most of w	orking			•	
21	d with giene or the	mo:	10	College (1-40) 54)	Mach	inist			Val.	ley Mach	ine	
	al Hy 1 oth	Be (17. Father's Name (First, Middle, Last)				18. Mother's N	ame (First, Middle	, Maiden	Sumame)		
yla	Ment Ment arked	2	Edward O. Bromelow					Waggle				
Maryland	and nand		19a. Informant's Name/Relationship (Ty)			g Address (Street					Code)	
	1 and Health		David Bromelow 20a. Method of Disposition	(son)		Formosa I sition (Name of natory or other place	-	Date		Z1/84 cation - City or To	wn, State	
Por	ages nt of nt of t: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	-	natory or other plac Mem. Par	_ 00	ine 24,				
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of the Traumatic event, the Medical Examiner must be notified at once.	1	21. Signature of Funeral Service License		22	. Name and Addre	ss of Facility	2004	- 5	esville,		
Ba	Depared Important		Jack like	flo	Bu	rrier-Que 12 W. Old	een Fune 1 Libert	ral Home v Road W	and infi	Cremato eld. MD	ry, P.A. 21784	
t.			23a. Part 1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the death							Approximate Interval Between	
	Physician	0.7	Immediate Cause (Final disease or condition		suffic	iency	with h	vner Kalemi	a 4 a	CIDOSIS	Onset and Death	
	/Medical		resulting in death)	Due to (or as a consequ		0		1				
	Examiner		Sequentially list conditions,	atherosi		2.						
	pe sit	Jine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ		E la pera	·	collin pa	6000	. You		
_6	xecut and al-trar	Examiner	that initiated events resulting in death) Last	Due to (or as a consequ	ence of):	- ischein	10 00	109011	Pis	<i>d</i>		
8760,	cate be executed physician and the burial-transit	dical		l								
9		led										
Вох	death certifi e attending id for use as	an/N	23b. was decedent pregnant	3c. If yes, outcome of pregnal 1 ☐ Live birth 2 ☐ Fetal		Ectopic pregnancy			2	23d. Date of delive Month	ry Day Year	
	that the death certif ed by the attending detached for use a:	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐ Pregnant at time of de 9☐ Unknown		Other (specify)				Month	Day 19ai	
P.0	The law requires that the site has been signed by the bage 2 should be detache	Phy	Part II. Other significant conditions con	tributing to death but not resu	Iting in the u	nderlying cause giv	en in Part I	23e. Did t	obacco u	se contribute to th	e cause of death?	
Vital Records,	signed to be det	d by	Fall II. Other algrilloans conditions con	inibating to doubt out not rose	inting in the di	identy in ig oddae o giv	OTT 11 T 12 T 1.			□No 3 □ Prob	100	
Sor	v requii	etec						24a. Was	an	24h Were auto	nev findings available	
Rec	The lav	ompleted						auto perfo	psy ormed?	death?	osy findings available npletion of cause of	
<u>ra</u>		ပိ	25. Was case referred to medical				26 Place of D	1 ☐ Yes eath (Check only of	20No	1 🗆 Yes	2LI No	
>	90 KA	OB	examiner?	ospital: 1 Impatient 2	ER/Outpatien	t 3 DOA Oth	0.00	Home 5 ☐ Resi		6 □Other (Specify	")	
٥٠ ا		n; T	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	28c. Injur Wor	y at k?	28d. Describe	how injury	y occurred		
Siol	Attending or death. ector: Afte by the fune	atle	2 ☐ Accident investigation			M 1 🗆	Yes 2 □No		_			
Division	or Att	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (City or To	Street and wn, State,	d Number or Aura)	l Route Number,	
	pital ours a eral [Ce	29a. Certifier 1X Certifying Physics	sician: To the best of my know	wledge death	occurred at the tir	no date and nia	ce, and due to the	cause(s)	and manner as st	ated	
	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	edical		ner: On the basis of examinat and manner stated.								
	To the To the To the To the Somple	Me	29b. Signature and title of certifier	21		29c. Licens	e number		29d. Date	e signed (Month, I	Day, Year)	
)			1 Baliran 10	58736	9	6	121/04	f				
	(X)		30. Name and address of person who co			Print)	.,	ter M	^	711	7	
	[)		412 Suite 304	Malcolm	Blud	me	Dimins	rer 1/1	1)	0110	7	
8	Sta Registi		31. Date filed (Month, Day, Year)	Malcolm 32. Registrar's Signa	DO NO	وع						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2004 Month June 24, **Physician** 10:30 a^M Vernice Yumei Breslin /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 209 South Rock Glen Road Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

4.4 Vrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Jan 11, 1960 9. Birthplace (State or Foreign Country) Japan 5. Social Security Number **Funeral** 44 Yrs. 1 M 2 F 224-02-9197 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner pust be notified at N/A 1 Yes 2 □ No Baltimore Director 10g. Citizen of What Country? 10e Street and Number 10f Zin Code ō 209 South Rock Glen Road 21229 United States or Items 23a 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Maryland 21215-0036 1 ☐ Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Health Care Il Hygiene. College (1-4or 5+) 5+ Elementary/Secondary (0-12) Accupuncturist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked o any injury or other traumatic eve Ronald Robichaud Mivasan Yumei 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mr. Michael A. Breslin/Husband 209 South Rock Glen Road, Baltimore, MD 21229 altimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Jun 25 1 □ Burial 2 KI Cremation 3 □ Removal from State * 4 □ Donation 5 □ Other (Specify) Chesapeake Crematory 2004 Beltsville, MD 22. Name and Address of Facility Cremation and Funeral Alternatives 21. Signature of Funeral Service Licensee M00986 u 8717 Green Pastures Drive Baltimore, MD23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician A cute EUKEMIA year /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) P.O. Box 68760. physician a Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ģ in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes No 24a. Was an certificate has b rector, page 2 si autopsy performed? res 20 No 1 ☐ Yes or Attending Physician: director. 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 \ Homicide within 24 hours a To the Funeral C To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greene St. Baltimore MD Rapoport 22 Haron 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 2 5 2004 Registrar

ORIGINAL

			1 - For State Registrar	State of Maryla	ınd / Depa		Health and I	Mental Hyg	•	gible. ∩ I.	20076
	Physici /Medic		1. Decedent's Name (First, Middle, Las Thomas	Vincent		Bridges		2. Date of Deat Month June 21	th Day	Year	3. Time of Death 5:05PM м
	Examir		4a. Facility Name (If not institution, give Cherry Hill; Nurs	ing Home		Laure			Pri	nty of Death	George's
	Funeral Director		5. Social Security Number 6. Sec. 277–54–4067 Usual Residence of Decedent	x	s. last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, April 2	Year) 4,195	9. Birth Cou 4 Oh:	place (State or Foreign intry) 10
	e Maryland a-f show	ctor	10a. State 10b. County Maryland Prince 6		City, Town or Lo aurel	ocation					10d. Inside City Limits 1 ☐ Yes 2X No
	th with th	Funeral Director	10e. Street and Number 9001 Cherry Lane			10f. Zip Code 2070	8	1	og. Citizen d Unit	what Cou ed St	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Ia marked other than "natural", or Items 23e or 28e-1 show any injury or other traumatic event. The Medical Exaction must be notified at Ance.	by	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cut 1 ☐ Yes 21 No	Hispanic Origin? (S pan, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	В	ace - Amer lack, White city: Bla	, etc.
Maryland 21215-0036	within 72 ho nne. Ihan "natur e Medicel I	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occu kind of work done DO NOT use retire Homem	during most of wor ed)	king	16b. Kind of	Business/l	•
land 2	uld be filed v fental Hygis rked other i lic event, tt	To Be Co	12 17. Father's Name (First, Middle, Last) Harold	Bridges		Homen		ne (First, Middle, M		ame)	
	and 2 should lealth and Men m 27 la marke		19a. Informant's Name/Relationship (T. Michael Bridges (Son)	Laure	1, MD 2	t and Number or Ru ak Lane 0783				
Baltimore,	permit. Pages 1 and 2 Department of Health s Important; If item 27 It any injury or other tra 9002		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify, 21. Signature of Funeral Services License	Removal from State C1	cemetery, crer nesapeal		ory June		20c. Location Belts		
Ba	Depa Impo any i		transfr	yout	R 9		ral And C Avenue Si			ces D 20	910
THE RESIDEN	Fnysician /Medical Examiner	er	23a. Part1. Enter the disease of companions, or heart failure. List only of limediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a. Prostate Due to (or as a cons Due to (or as a cons	Cancer equence of):	or the mode or dy	ng, such as cardiac	or respiratory and	334,		Approximate Interval Between Onset and Death
68760,	icate be executed physician and s the burial-transit	dical Examiner	cause. Enter Underlying Tate J Lease of high that initiated events resulting in death) Last	c. Due to (or as a cons	equence of):						
.O. Box	death certif e attending d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	etal death 3	∃Ectopic pregnanc ∃ Other (specify) _	у			ate of deliv	nery Day Year
rds, P	The law requires that the site has been signed by the bage 2 should be detache	by	Part II. Other significant conditions co HIV Infection	ntributing to death but not r	esulting in the u	nderlying cause gi	ven in Part I.				the cause of death? bably 4 \text{VInknown}
I Records,	The law re cate has be page 2 sho	Completed	Hypertension Ascitis					24a. Was ar autops perform 1 Yes 2	y		opsy findings available ompletion of cause of
Vital	Phyalcian: Th r this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 📉 No	Hospital: 1 ☐ Inpatient 2	□ ER/Outpatier	nt 3□ DOA Ct	26. Place of Dea her: 4 X Nursing H	th (Check only one	-	ther /Speci	fv)
ion of	ding Afte fune		27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Inju Wo		28d. Describe ho			97
Division	or Dir	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm, str cify)	eet, factory, office		28f. Location (Str City or Town		nber or Run	al Route Number,
	e Hospital 24 hours a te Funeral I	edical	29a. Certifier 1 XCertifying Phy (Check only 2 Medical Examone)	rsician: To the best of my k iner: On the basis of exami and manner stated.	nowledge, death nation and/or in	h occurred at the t vestigation, in my	me, date and place opinion, death occu	, and due to the ca rred at the time, da	use(s) and rate and place	nanner as s , and due t	stated. to the cause(s)
t	To the l within 2 To the I	M	29b. Signature and title of certifier	7	ΛΛ	29c. Licen	se number	29	d. Date sign	ed (Month,	Day, Year)
,			30. Name and address of person who co	on rieted cause of death (It	em 23a) (Type,	Print) D45	217	J	une 23	,2004	
	C-33 531		Adebowale Ajayi, M	D 6201 Gree	nbelt R	d., Coll	ege Park,	Md. 2074	40		
	Sta Registi		JUN 2 5 2004	32. Registrar's Sig	1934	w					

			For 1 - State Registrar	State of	Maryland /	-	artmen rtificat			and M		giene Rag. NO ()	0.1	00077
Γ			Decedent's Name (First, Middle,	Last)		~					2. Date of Dea	ath 💆 U	U !+-	-8. Time of Death
	Physici /Medic		Lydia M. Bu	hite							Month JUN	Day	Year 200.	4 2:30 P M
	Examin		4a. Facility Name (If not institution,				4b. City,	Town, or	Location o			4c. Cour	nty of Death	
			Saint Joseph				If Under	1 Vear	If Under:	OWSC				timore
	Funeral Director		5. Social Security Number 6 217–16–1573	i.Sex 7 1 ☐ M 2 X F	'. Age (In yrs. last i 83	Vrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Day Oct. 27	r, _{Year)} 7, 1920	9. Birth Coi	nplace (State or Foreign intry) 'yland
			Usual Residence of Decedent								000. 27	, 1220	1101	утапи
	trylan show		10a. State 10b. County		10c. City, To	own or Lo	ocation							10d. Inside City Limits
	8e-f	Director		ltimore		Rand	allst							1 ☐ Yes 2X No
	with ti		10e. Street and Number				10f. Zip					10g. Citizen o		untry?
	s 23	eral	3706 Sonara Ro		lent Ever in U.S.	13	Mas Door		1133	ain? /Soc	oifu Vac or Na	14 8	USA	ican Indian,
10	ours after death with the Marylan al', or Items 23e or 28e-f show Examiner must be notified at	Funeral	1 ☐ Never Married 2 ☐ Married	Armed Ford	ces? ZX∏No	1			n, Mexican	, Puerto	cify Yes or No- Rican, etc.)	В В	lack, White	
03		by	3√ Widowed 4 Divorced	If Yes, Give Year or Da	tes:		1 ☐ Yes	2 X No	Specify:			Spec	cify: U	Jhite
21215-0036	be filed within 72 hours ital Hygiene. Id othar then "natural", evant, the Medical Exa	Completed	15. Decedent's (Specify only highest		16	(Give	dent's Usua kind of wo	rk done a	turina most	t of worki	ng	16b. Kind of	Business/I	ndustry
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d 2	e filed Il Hygie othar vant, II	e Co	12 17. Father's Name (First, Middle, La	ist)		етер	hone	uper		r's Name	(First, Middle,			cations.
Maryland	thould be id Mental markad o metic eve	To Be	Arthur Pinde							Norm				
ary	S D E E	-	19a. Informant's Name/Relationship	(Type, Print)	1:	9b. Mailir	ng Address	(Street a	and Numbe	r or Rura	l Route Numbe	r, City or Tow	n, State, Z	ip Code)
	Health a tam 27 Is		Mrs. Barbara Ann	Flint/Da	ughter 3	706	Sonar	a Rd	. Rar	dall	stown,_	Maryla	and 21	133
Baltimore,	o jo		20a. Method of Disposition 1 XBurial 2 Cremation 3	Removal from S	20b. Place ceme	of Dispo	natory or o	ne of ther place	θ)	D	ate	20c. Location	n - City or 1	own, State
Ë	. Pages tment of tant: If Its jury or o		*4 ☐ Donation 5 ☐ Other (Spe	city)										laryland
Bal	permit. Pag Department Important: I any injury c		21. Signature of Funeral Service Lie	censee	01									dome, Inc.
			23a. Part1. Enter the disease, or of shock, or heart failure. List	nplications that ca	sed the death. D		1050 er the mod				r respiratory ar		10 212	Approximate
	Priysician i		Immediate Cause (Final					, , ,	,		,			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a SLES Due to (o	r as a consequenc	e of):							-	
	Examiner		Sequentially list conditions	b. URIN	ARY TRE	ACT	INFE	CTI	JN					
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	ecute and I-trans	Examine	that initiated events resulting in death) Last	c. Due to (o	r as a consequenc	e off:							_	
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687	ificate g phys as the	Physician/Medical		d.										
Вох	eath certific attending p	In/M	IF FEMALE: 23b. Was decedent pregnant		ome of pregnancy th 2 Fetal dea	th 3]Ectopic pr	0000000				23d. D	ate of deliv	ery
Э.	ed for	sicia	in the past 12 months? 1 ☐ Yes 2 🕱 No		nt at time of death		Other (sp					,	Month	Day Year
P.0	that the de ed by the a detached t	Phy	9 Unknown			- t- M					no- Dida-	<u> </u>		
S,	signe	l by	Part II. Other significant conditions Hypertension	s contributing to dea	un dui not resultinç	g ar ine ui	naenying c	ause give	n in Part I.		239. Did to		ntribute to	the cause of death? bably 4 □Unknown
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Vital Records,	he far e has age 2	Completed			<u> </u>						autop: perfor	sy med?	prior to co death?	ompletion of cause of
		a	Crohn's Diseas	se					26. Place	of Death	1 ☐ Yes (Check only or	2 No	1 🗆 Yes	2 X No
f V	ysic lis ce dire	To B	examiner? 1 □ Yes 2 No	Hospital: 1 In	patient 2 ERV	Outpatien	it 3 DO	A Cthe			ne 5 ☐ Resid		ther (Speci	fy)
			27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of (Month	Injury 28b , Day Year)	. Time of Injury	2	8c. Injury Work	at		8d. Describe h			
sio	Attanding r death. actor: After by the fune	cati	2 Accident investigat 3 Suicide 6 Could not	t be			М		'es 2 □ N					
É		Certification:	4 Homicide determine	288. Place C	of Injury - At home, g, etc. (Specify)	farm, str	eet, factory	, office		2	81. Location (S. City or Tow	treet and Num n, State)	nber or Rur	al Route Number,
_	To tha Hospital or within 24 hours afte To tha Funaral Dir completely filled in		29a. Certifier 1 Certifying	Physician: To the b	est of my knowled	lge, death	Occurred	at the tim	e, date and	place a	nd due to the o	ause(s) and a	nanner as s	stated.
	a Ho 24 h a Fur fetely	edical	(Check only 2 Medical Ex	aminer: On the bas and manne	sis of examination a	and/or inv	vestigation,	in my op	inion, deat	h occurre	d at the time, d	late and place	, and due t	o the cause(s)
	To tha I within 2 To tha I complet	Me	29b. Signature and title of certifier	1			290	. License	number			29d. Date sign		Day, Year)
if.	1		(ten	ww	Como			D 37	7254		4	51231	04	
	り		30. Name and address of person wh	no completed cause	of death (Item 23a	a) (Type,	Print)							
			31. Date filed (Month, Day, Year)	7601 05	LER DRI	VE	TOWS	ON,	MARY	ALAN	D 2120	34		
	" Sta Registr		AUN 2 5 2004	- /	Je S	1	pour	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - Stete Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year John Bart Butt une 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Loseda enter attimore Mare DITA If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)
Oct. 11, 1918 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 9. Birthplace (State or Foreign 1**∑**M 2□ F Months 216-12-6472 85 Yrs. Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Baltimore Perry Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4701 Forge Road Department of Health and Mental Hygiene. Important: If item 271a marked other than "natural", or Items 23a any injury or othar traumatic evant, Ite Madical Examiner must botice. 21128 u.s.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes 2 X No Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: Be Completed by White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Continental Can Elementary/Secondary (0-12) College (1-4or 5+) 6th Grade Warehouseman Corporation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Lawrence Butt Caroline Kahl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Clara M. Butt (wife) 4701 Forge Road. Perry Hall. MD 21128 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State St. Joseph Church Cem. 6/28/04 Fullerton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the burial-transit To the Hospital or Attanding Phyaician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 physician by Physician/Medical SIDY IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐ Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has 20 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 ☐ Yes 2 No this 28b. Time of Injury 27. Manner of Death Date of Injury (Month, Day Year) 28d. Describe how injury occurred I Diractor: After t d in by the funera Certification; 1 Natural 2 Accident 5 Pending investigation death. 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral I 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

30. Name and address of person who completed cause

5

Square Drive Baltimore,

death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death June **Physician** Whitehill James Barnes 2004 12:30A M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Northampton Manor Health Care Ctr. Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Month, Day, Year) Feb. 1, 1908 9. Birthplece (State or Foreign **Funeral** 12 M 2□F Mary land 218-30-7842 96 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits s 23a or 28e-f show Maryland Frederick 1 ☐ Yes 2 No Directo Thurmont 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21788 6003 Mountaindale Rd. U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 🕇 No à Specify: Specify: White 3 → Widowed 4 Divorced "natural" Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) rthan Elementary/Secondary (0-12) College (1-4or 5+) farmer dairy .. Pages 1 and 2 should be filed w trinent of Health and Mental Hygien tent: if item 27 is marked other ti jury or other fraumatic avent. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James G. Barnes Florence Whitehill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert J. Barnes/ son 6003 Mountaindale Rd. Thurmont, MD 21788 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State importent: if it any injury or o once. 1 Burial 2 □ Cremation 3 □ Removal from State Fairmount Cemetery 6/26/2004 Libertytown, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hartzler Funeral Home Dermit. 21. Signature of Funeral Service Lig 11802 Liberty Rd. Libertytown, MD 21762 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final netastatic liver concer Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year Day signed by the at the detached for 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, cile 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably should been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s has autopsy performed? res 200 No Alzheinecertificate Vital 1□ Yes 25. Was case referred to medical examiner? filled in by the funeral director, Be 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ 3 DOA of 27. Manner of Death

1 △Natural

2 ☐ Accident 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division Hospitel or Attending Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 D53129 NO 6/22/04 use of death (Item 23a) (Type, Print)
MD 610 Solarex Ct, Frederick, MD, 21703 30. Name and address of person who completed Heit Dale ZI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JUN 2 5 2004

	State of Maryland / Department of Health and Mer	, ,	ene . N2 11 14 2	0000
Physician /Medical	1. Decedent's Name (First, Middle, Last) 2.	Date of Death Month		Time of Death C430 AM
Examiner	4b. City, Town, or Location of Death 3949 Walthout Woods Rd. Ap + E 5. Social Security Number 6. Sex, 12 M 2 F 12 M 2 F 13 M 2 F 14 City, Town, or Location of Death 4b. City, Town, or Location of Death 4b. City, Town, or Location of Death 4c City, Town, or Location of Death 4c City, Town, or Location of Death 4c City, Town, or Location of Death 4c City, Town, or Location of Death 4c City, Town, or Location of Death 4c City, Town, or Location of Death 4c City, Town, or Location of Death 4c City, Town, or Location of Death 4c City, Town, or Location of Death 4c City, Town, or Location of Death 4c City, Town, or Location of Death 4c City, Town, or Location of Death 4c City, Town, or Location of Death 4c City, Town, or Location of Death 4c City, Town, or Location of Death 4c City, Town, or Location of Death 4c City, Town, or Location of Death	Date of Birth (Month, Day, Ye	4c. County of Death BALTI MOR	CE (State or Foreign
or 28s-1 show	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code	10g.		nside City Limits Yes 2 No
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Modical Exerture must be maited at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Amiled Forces? 1 Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rical III) Yes, Specify: 13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rical III) Yes, Sive Year or Dates:		14. Race - American Ir Black, White, etc. Specify: White	te :
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1 and 2 should be Health and Mental em 27 Is marked of ther traumatic ev	JOSEPH BARRANCO 19a. Informant's Name/Relationship (Type, Print) BRVIR J DARRANCO - W. L. P44 WH am W. C. Date 20b. Place of Disposition (Name of Disposition (Name of Disposition)	Apt 8.	ity or Town, State, Zip Cod ATT Location - City or Town,	EMO'
permit. Pages Department of I Important: If its any injury or o Once.	1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 6/25/(4 Donation 5 Other (Specify)	THORE	DRESTHILL , mD 21234 ARFORDRA	MA
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cate be executed by sician and the burial-transit dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): d.	n ch	Ocare	
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hys hidi		neck only one) 5 X Residence Describe how in		
pital or Attending Pours after death. eral Diractor: After ifilled in by the funeral I Certification;	4 Homicide building, etc. (Specify)	City or Town, S		te Number,
To the Hosp within 24 hot To the Fune completely fil	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and of the course of examination and/or investigation, in my opinion, death occurred at and manner stated. 29b. Signature and title of certifier 29c. License number	t the time, date	e(s) and manner as stated, and place, and due to the of Date signed (Month, Day,	
	T. Crossem O Honorom, MD D0007632 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			.004
State Registrar	J. CROSSAN O'DONOVAN MD 2112 DUNDALICA 31. Date filed (Month, Day, Year) 32. Registra's Signature JUN 2 5 2004 JUN 2 5 2004	VE	BALTO MO	21222

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			For	State of Mary	-			lental Hygie	ne	
			1 - State Registrar		Ce	rtificate of I	Death	Reg.	MG NO!	20001
	Physici	an	1. Decedent's Name (First, Middle, Las		CLARK			Date of Death Month	Day Year	-3. Finde of Death
	/Medic	al	7.1.	JEN KINS	CEMICA	4h City Town or	r Location of Death	JUNE 23		2:40 PM
	Examin	er	4a. Facility Name (If not institution, give				noire, m	D 21230	4c. County of Death	
	Funeral		5. Social Security Number 6. Se		n yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		
	Director		214-62-8499 1	DM 2107 H9	Yrs.	Months Days	Hours Min.	Month, Day, Ye	1954MA	place (State or Foreign Intry) RU A
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	death	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race - Amer	
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21215-0036	within 72 hours after death with the Maryland ene. then "neturel", or Items 23e or 28e-f show the Modical Exacting rough by norifiked at	d by	3 Widowed 4 □ Divorced	Year or Dates:					N/	ACIC
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/lar	should be and Mental marked o	To E	BRUGE JENK	ns SR			Lilli Ar	· T, 1	ahmar)
Maryland	2 shc and is m		19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailir	ng Address (Street a	and Number or Rur	al Route Number, Ci	or Town, State, Zi	p Code)
	of Health of Health item 27		DRUCE JEN	Kins Dr	20b. Place of Dispo	RESDU	Ry STR	CE Society 200	Alto, M	13/2/6
סר	Pages 'nent of H		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	cemetery, crer	natory or other plac	الع	1	. Location - City or T	own, State
altimore,	permit. Pag Department Importent: I any injury o		* 4 □ Donation 5 □ Other (Specify 21. Sign to re of Funeral Service Licen		MT. Lic	n (eme	tarry Jun	2787004	Amedoun	E MODA
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8760,	icate be executed physician and the burial-transit	aiE			37.004007.00 07,					
687	ficate physics the	edicai	1-1-1	d						
Вох	nding use a	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p					23d. Date of deliv	ery
œ	death	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
P.O.	that the death certificed by the attending posterior detached for use as	Physician/Me	9 🗷 Unknown							
	res tha igned be dei	by	Part II. Other significant conditions of	A	ot resulting in the u	nderlying cause give	en in Part I.		o use contribute to t	
ord	v requir been s should	eted		19/200		_		1 L Yes	2 ∐No 3 ☐ Proi	pably 4 @Onknown
Sec.	2 3 3	Completed	- MIO CVA	- On 1 have	0 1	1.001		24a. Was an autopsy performed	prior to co	ppsy findings available impletion of cause of
al F	ilcien: Th certificate rector, pag		- ESRD WW 0	n peutone	ent dia	egers		1 ☐ Yes 2 🖼		2 🗆 No
Division of Vital Records,	Physicien: this certificaral director, I	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ N6	Hospital:	2 D E D (0	Othe	ar.	(Check only one)		
ō	y Phys arthis eraldii	n: To	27. Manner of Death	28a. Date of Injury	2 ER/Outpatien	1 3 DOA	4 Li Nursing Ho	me 5 Residence 28d. Describe how in		(y)
o	ttending l death. ctor: After y the funer	Certification:	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Ye	ear) Injury		<br Yes 2□No			
Vis	l or Attenoration after death Director: In by the	tific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - building, etc. (S		eet, factory, office		28f. Location (Street City or Town, St		al Route Number,
Ω	itel o irs aft rel Di led in						<u> </u>			
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate ht completely filled in by the funeral director, page	edicai	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	vsician: To the best of m	amination and/or inv	occurred at the time restigation, in my op	ne, date and place, s pinion, death occurr	and due to the cause ed at the time, date a	o(s) and manner as s and place, and due to	tated. the cause(s)
	o the ithin 2 o the omple	Med	29b. Signature and title of certifier	and manner stated.	•	29c. License	e number	29d.	Date signed (Month,	Day, Year)
	≓≱≓ö		NIION Refel	mo		RESC			123/2004	
			30. Name and address of person who d	ompleted cause of death	(Item 23a) (Type.	Print)			/	
1	2		NILESH PATER			RAVEN	Bouleva	DKY BALT	more, mo	21239
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	1 -				

DHMH 17 Rev 1/2001

JENKINS

1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician /Medical Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4b. City, Town, or Location of Death	WSON Baltimore Hrs. 8 Date of Birth 9 Birthplace (State or Except)
/Medical Josephine Montague Unilds	JUNE 24, 2004 7:44A M Death
Avecured the control of the control	Ac. County of Death WSON Baltimore Hrs. 8 Date of Birth 9 Birthplace (State or Except
	Hrs. 8 Date of Birth 9 Birthplace (State or Foreign
	Min. (Month, Day, Year) Country)
Director 257-40-6425 76 Yrs. Usual Residence of Decedent	Sept. 12, 1927 Geőrgia
0	10d. Inside City Limits
Baltimore Lutherville	1 ☐ Yes 2 💢 No
MD Baltimore Lutherville MD Baltimore University 106. Zip Code	10g. Citizen of What Country?
21093 21093	United States
Tools State 10a. State 10b. County 10c. City, Town or Location	? (Specify Yes or No- ruerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of	16b. Kind of Business/Industry
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker	
To be set to be	Own Home
To the first of the part of th	Name (First, Middle, Maiden Surnarne) Hoyle Nash
Tark of planed as a second of the planed as a second of the planed as a second of the planed of the	or Rural Route Number, City or Town, State, Zip Code)
John C. Childs, Sr./spouse 2211 Boxmere Road	Lutherville, MD 21093
O - Place of Disposition	Date 20c. Location - City or Town, State
1 Burial 2 Scremation 3 Removal from State Hilltop Svc. Corp.	/25/2004 Towson, MD.
20a. Method of Disposition 20a. Method of Disposition 1 Burial 2 Scremation 3 Removal from State 1 Burial 2	Ruck Towson Funeral Home, Inc. Towson, MD 21204
23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car shock, or heart failure. List only one cause on each line.	
Immediate Cause (Final disease or condition resulting in death)	Onset and Death
Due to (or as a consequence of): Examiner ISCHEMIC CARDIOMYOPATHY	
Sequentially list conditions.	
If any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
resulting in death) Last Due to (or as a consequence of):	
Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Course (Disease or injury that initiated events resulting in death) Last Course (Disease or injury that initiated events resulting in death) Last Course (Disease or injury that initiated events resulting in death) Last Course (Disease or injury that initiated events resulting in death) Last Course (Disease or injury that initiated events resulting in death) Last Course (Disease or injury that initiated events resulting in death) Last Course (Disease or injury that initiated events resulting in death) Last Course (Disease or injury that initiated events resulting in death) Last Course (Disease or injury that initiated events resulting in death) Last	
23b. Was decedent pregnant in the past 12 months? 1	23d. Date of delivery Month Day Year
	23e. Did tobacco use contribute to the cause of death?
ATRIAL/VENTRICULAR ARRHYTHMIAS	1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown
ATRIAL/VENTRICULAR ARRHYTHMIAS ATRIAL/VENTRICULAR ARRHYTHMIAS HEMOLYTIC ANEMIA 25. Was case referred to medical examiner? Hospital: Arrive and a control of the control	24a. Was an 24b. Were autopsy findings available prior to completion of cause of
The Dage has been had	performed? death?
25. Was case referred to medical examiner? Hospital: The control of the control	Death (Check only one)
1 Inpatient 2 IEN/Outpatient 3 DOA 4 Nursin	ng Home 5 Residence 6 Other (Specify)
27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 1 Natural 5 Pending (Month, Day Year) 4 Natural 1 Yes 2 No	28d. Describe how injury occurred
The second secon	28f. Location (Street and Number or Rural Route Number.
27. Manner of Death 1	City or Town, State)
Signature and title of certifier 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29e. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number	lace, and due to the cause(s) and manner as stated. occurred at the time, date and place, and due to the cause(s)
graph of the second of the sec	29d. Date signed (Month, Day, Year)
Sichard Luthicum D 31826	10-24-04
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
RICHARD L. LINTHICUM M.D. 7601 OSLER DRIVE	TOWSON MARYLAND 21204
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	
Registrar DHMH 17 Rev 1/2001 DHMH 25 2004 Section 5 Apocks	

			For State	State of M	laryland	-	artment of H		d Mental Hy		0.01	00000
			State Registrar 1. Decedent's Name (First, Middle)	(act)		Cel	lineale of L		2. Date of De	Reg. No.	خللا	3. Time of Death
	Physicia	an	200				Osea abre	Can	June	19	2004	3:15a. ^M
5	/Medic		Louis 4a. Facility Name (If not institution,		enry		Crosby 4b. City, Town, or			- 	ounty of Deeth	J.1Ja.
	Examin	er	Lorien Frankí			Ome	Baltime				. , , , , ,	
	Funeral		5. Social Security Number	6. Sex 7. A	ge (In yrs. Ia		If Under 1 Year	II Under 24	Hrs. 8. Date of Bir Min. (Month, Da	th Vear	9. Birth	place (State or Foreign
и	Director		228-01-6286	1 X M 2□ F	87	Yrs.	Months Days	Hours	10 1	7 1	6 Coui	VA
	D .		Usuel Residence of Decedent 10a. State 10b. County		10c City	, Town or Lo	scation					10d. Inside City Limits
	aryla	-										1 X Yes 2 □ No
	he M	Director	MD NA 10e, Street and Number		Ва.	ltimo	10f. Zip Code			10g. Citize	en of What Cour	ntry?
	death with the Maryland ms 23s or 28s-f show rmat be notified at	늅						215		•	U.S.A.	-
	Jeath	Funeral	2414 Oswego P	12, Was Deceden	t Ever in U.S	3. 13.			? (Specify Yes or No Puerto Rican, etc.)		Race - Ameri	can Indian,
က	or Iter	Ē	1 Never Married 2 Marri	Armed Forces 1 Yes 2 1 If Yes, Give	No.			Specify:	Puerto Rican, etc.)		Black, White, pecify:	etc.
21215-0036	within 72 hours efter ene. than "natural", or ite	d by	3 Widowed 4 Divorced	Year or Dates	:						В.	ack
5	natu	Completed	15. Decedent (Specify only highes	s Education t grade completed)		16a. Dece (Give	dent's Usual Occupa kind of work done d DO NOT use retired,	tion uring most o	f working	16b. Kind	of Business/In	dustry
7	within ane. than	m d E	Elementary/Secondary (0-12) 9th grade	College (1-40)	r 5+}		ngshore			Frei	aht Ir	ndustry
	be filed within 72 hours efter death with the Marylan lat Hygiene. Id other than "natural", or Items 23a or 28a-f show event, the Madical Examiner mant be notified at		17. Father's Name (First, Middle,						Name (First, Middle			
an	d be ental ked o	To Be	Peter Crosby					Em il y	Robinso	n		
Maryland	2 should by and Menta is marked eumatic e	-	19a. Informant's Name/Relations	nip (Type, Print)		19b. Maili	ng Address (Street a	nd Number	or Rural Route Numb	er, City or T	Town, State, Zip	Code)
	rtr		Catherine M.	Crosby-W:					Baltimo	ore M	d 212	215
Baltimore,	00		20a. Method of Disposition 1 Burial 2 □ Cremation	3 □Removal from Stat	20b. Pla	ace of Dispo metery, crea	sition (Name of matory or other place	e)	Date	20c. Loca	tion - City or To	own, State
Ĕ	Pag nent ant: I		'4 □Donation 5 □Other (S		Kin				/24/04	Rand	allsto	wn, Md
Salt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service	License		Ma	Name and Address	west				1015
	₹0 <u>=</u> a		Alome	Sed outs					e, Balti		Ma 2	21215 Approximate
			23a. Part1 Enter the disease, or shock, or heart failure. List	only one cause on each	line.	. Do not en	ter the mode of dyini	g, such as ca	a	iii est,		Interval Between Onset and Death
Ž.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	- a. (0 s		vaser	In R	Jeco	lent			
	Examiner			Due to (or a	is a consequ	ience of):						
	5- 4	e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or e	is a consequ	rence of.	\					
	te be executed ysician and te burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Ltu.	1 de	W 8 W	n.					
oʻ	te be executed ysician and e burial-transit		resulting in death) Last	Due to (or	a consequ	ience of):						
3760	ate be hysici he bu	icai		d	rocer	me						
89 x	The law requires that the death certificat the has been signed by the attending phy tage 2 should be detached for use as the	Physician/Med	IF FEMALE:	22a Hunn autonom		***	27.57				William I	
Вох	ath co	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 Live birth 4 Pregnant	2 Fetal	death 3[Ectopic pregnancy Other (specify)			23	d. Date of deliv Month	ery Day Year
o.	at the de by the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown		3 4(1) 3(
٥.	that the detail		Part II. Other significant condition	ons contributing to death	but not resu	ulting in the u	inderlying cause give	en in Part I.	23e. Did	tobacco use	e contribute to t	he cause of death?
Records,	puires n sign ald be	d by	Benja	proshh	· /	W 128	hophy		1 🗆	Yes 2□	No 3 ☐ Prol	bably 4 Honknown
00	w require been si should t	Completed	Se Arran vo	desiral	lo_	()	1 1		24a. Wa		24b. Were auto	opsy findings available
Re	The lav	шо	- Scryvec							ormed?	death?	ompletion of cause of 2□ No
Vital		0	25. Was case referred to medica					26. Place o	f Death (Check only			
f V	Physician: this certific ral director.	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpa	utient 2 🗆 I	ER/Outpatie	nt 3 DOA Othe	er: 4 Nurs	ing Home 5 ☐ Res	idence 6	□Other (Speci	(y)
n of	ng Ph fter th neral		27. Manner of Death 1 ☐Natural 5 ☐ Pendir	28a. Date of Ir (Month, I	njury Day Year)	28b. Time of Injury	Worl	(?	28d. Describe	how injury	occurred	
Division	uttendii death. ctor: A y the fu	Certification:	2 Accident investi	gation				Yes 2 □ No		/O+	March and Good	of Books Months
Ž	d or Att	Ē	4 Homicide determ	200. Place of	Injury - At ho etc. (Specify	me, larm, st /)	reet, lactory, office			(Street and wn, State)	Number or Hur	al Route Number,
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier 19 Certifyli	ng Physician: To the be	st of my know	wiedne den	th occurred at the time	ne, date and	place, and due to the	causals) s	nd manner as s	stated.
	To the Hospite within 24 hours To the Funeral completely filled	Medical	(Check only 2 Medical one)	Examiner: On the basis and manner	of examinat	tion and/or in	ivestigation, in my of	oinion, death	occurred at the time	, date and p	lace, and due t	o the cause(s)
	o the	Me	29b. Signature and title of certifie	r			29c. License			29d. Date	signed (Month,	Day, Year)
	->-0) OC	Wash		MD	D	3146	4	61	51100	1
	li		30. Name and address of person	who completed cause of	f death (Item	1 23a) (Type	. Print)	0	C A	20	0	
_			SitoAIB A.	H4814M	1, 8:	21 N	Zulaw	or	Inte -	101	1800	MD 2/201
		ate rar	31. Date filed (Month, Day, Year) JUN 2 5 2004		strar's Signa	gre 1	bach					

DHMH 17 Rev 1/2001

Registrar

1-0	4071	For State of the year of the or Houter and Worker Tryglone													
_		1 - State Registrar Certificate of Death Reg. No. 101. 2005								181					
	Physici	an	Decedent's Name (First, Midd	dle, Last)							2. Date of Month		Day Ye	ar 3. Time	of Beath
	/Medic	al	Walter		Marsha	11			Cox_		June	= 19,	2004	072	0 A. M
1	Examin	er	4a. Facility Name (If not institution Maryland Gene	. 0	·		46. Ci	y, Town, or Balt.				-	tc. County of D)eath	
	Funeral	-	5. Social Security Number	6. Sex		. last birthday)		er 1 Year	If Under		8. Date	of Birth	9.	Birthplace (Stat	e or Foreign
	Director		218-37-8730	XIXM 2□F	62	Yrs.	Month	s Days	Hours	Min.	11	h, <i>Day</i> , Yea 07	41	Country) \ MD	
	pu 🛊 😘		Usual Residence of Decedent 10a. State 10b. Count	v	10c C	ity, Town or Lo	cation		-					10d Incide	City Limits
	sho	ō		,		timor									es 2 No
	28a-i	rect	MD NA 10e. Street and Number	 	Dal	CIMOL		ip Code				10g (Citizen of What	****	
	with 3c or	Ö	822 Newingt	on Ave					1217			3.	U.S.	•	
	death ms 2;	era	11. Marital Status	12. Was Dec	edent Ever in t	J.S. 13.	Was Dec	edent of Hi		igin? (Spe	ecify Yes	or No-	14. Race - A	kmerican fndian,	
9	be filed within 72 hours after death with the Maryland ntal Hygiene. so other then "neturel", or Items 23c or 28a-f show event, Ite Medical Evertiver mast be neithed at	Completed by Funeral Director	1 ☐ Never Married 2 🔀 Ma	rried Armed Fr	2 V No			ecify Cuba	n, Mexicai Specify:		Rican, etc	:.)		Vhite, etc.	
003	ours	d by	3 ☐ Widowed 4 ☐ Divorce	d Year or E	Dates:								Specify:	Black	
21215-0036	C 2 20	iete		nt's Education est grade completed)		16a. Deced (Give life.	kind of	vork done	ation Juring mos	t of worki	ng	16b.	Kind of Busine	ess/Industry	
12	filed within Hygiene. other then "	шc	Elementary/Secondary (0-12)		1-4or 5+)			visor					Wareh	01150	
	filed Hygie other	a	12th grade 17. Father's Name (First, Middle	, Last)		<u> </u>	per	VISO		er's Name	(First, M	iddle, Maide	on Sumame)	ouse	
al	should be filed within and Mental Hygiene. marked other then matic event, I a M	To B	William Cox						Mari	an 1	Book	er			
Maryland	s 1 and 2 should I f Health and Meni item 27 is marker other treumatic		19a. Informant's Name/Relation	ship (Type, Print)		19b. Mailir	ng Addre						or Town, Stat	e, Zip Code)	
	Health Health tem 27		Josebell Cox	-Wife					on A			imor	e Md	21217	
ore	iges 1 ar it of Hea if item or other		20a. Method of Disposition 1X Burial 2 □ Cremation	3 □Removal from		Place of Dispo cemetery, crer	natory o	ame of other plac	э)	, c	ate	20c.	Location - City	or Town, State	
Ë	Pages tment of tent: If it		' 4 □ Donation 5 □ Other (Specify)		ng Me					5/04	l Ra	ındall	stown,	Mđ
Baltimore,	permit. Pages. Department of H Importent: If ite any injury or of		21. Signatule of Funeral Service			M	arci	and Addres	I We	śt			24.7	0101	-
			23a. Part 1 Enter the disease, of	or complications that	caused the dea	th. Do not ent	300 er the m	Waba ode of dvino	sh such as	AVE ,	Ba.	time orvarrest	re Md	2121 Approxim	
	Physician		shock, or heart failure. Lis Immediate Cause (Final disease or condition			notic (reli	137650	Jar	dica	060			Interval E Onset an	d Death
	/Medical Examiner		resulting in death)		(or as a conse		2100	00000	<u>Groot</u>	Day					
R	LAGITITICI	1	Sequentially list conditions,	b. Due to	(or as a conse	quence of):									
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	⊀ 555.5	(01 23 2 001130	querice ory.									
,	icate be executed physician and s the burial-transit	Exal	that initiated events resulting in death) Last	c	(or as a conse	quence of):									
68760,	re be ysicia e bur	edicai		d											
_			IE EEMAN E												
Вох	The law requires that the death certificate has been signed by the attending to bage 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant		tcome of pregn		Ectopic	pregnancy					23d. Date of		\
.O.	ie dea the at	/sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□ Pregi 9□ Unkr	nant at time of lown	death 5□	Other (specify)				-	Month	Day	Year
Q	res that the de signed by the a be detached		Part II. Other significant condit	ions contributing to d	leath but not re	sulting in the u	nderlying	Callee dive	n in Part I		230	Did tobacco	use contribute	e to the cause o	f death?
Vital Records,	signe d be	d by	Ischemic sr			1		4	alcul	Ta				Probably 4	
Ö	w requir been si should	iete	henal fail		00000	T GOVE		11115	- Cuit	<u> </u>		Mas an			
Re	he lav e has ige 2	Completed	henal fall	mre.							~ F	utopsy performed?	prior		cause of
tal		ø	25. Was case referred to medic	at					26 Place	of Death	(Check o	es 2 N	0 120	(es 2□ No	
<u>></u>	S S S	To B	examiner? 1XYes 2□No	11	npatient 2	ER/Outpatien	it 3 🗆 [Othe	-		•		6 □Other (S	pecify)	
J of	부 는 ja		27. Manner of Death 1 XNatural 5 ☐ Pend	28a. Date		28b. Time of Injury		28c. Injury Work					ury occurred	, , , ,	
Ö		atic	2 ☐ Accident inves	tigation		,,	М		'es 2□	No					
Division	ire ter	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deten	mined 286. Place	of Injury - At hing, etc. (Spec	nome, farm, str ify)	eet, facto	ry, office		2	28f. Locati City or	on (Street a Town, Sta	and Number or te)	Rural Route Nu	ımber,
	pitel ours a sere! D		29a. Certifier 1□ Certify	ing Physician, To th	- hant of multip					1 -1		41- /			
	To the Hospitel of within 24 hours af To the Funerel D completely filled in	edicai		ing Physician: To the I Examiner: On the b and man	asis of examin ner stated.	ation and/or inv	estigatio	n, in my op	e, date an inion, dea	th occurre	ed at the ti	me, date ar	s) and manner nd place, and c	as stated. lue to the cause	(s)
	To th within To th comp	Me	29b. Signature and title of certifi	er			2	9c. License				29d. D	ate signed (Mo	2004 Year)	
)	1		Joisher	Theers	ey MI	b		July	سبد			Ju	641	2001	
	5		30. Name and address of person	n who completed cau	se death (Ite	m 23a) (Type,	Print)11	1 Per	n St	reet,	, Bal	timor	e, Mary	yland 21	1201
	.,		Jasha L (rvoen ber	JAID.										
	Sta * → Registr		31. Date filed (Month, Day, Year JUN 2 5	2004	egistrar's Sign	A LUIB	Spe	uls	,						

Mary Craig 04-3993 AKG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

G	<i>)</i>		1 - For State Registrer		epartment of Health and Certificate of Death		ene g. 2 .004	20085
	Physici	an	1. Decedent's Name (First, Middle, La	st) .		2. Date of Death Month	3	3. Time of Death
	/Media	al	4a. Facility Name (If not institution, give	ralg	4b. City, Town, or Location of De-	June 17	-	1:00 P M
	Examir	ier	904 W. Lexington		Baltimore		MA	-
	Funeral		5. Social Security Number 6. S		(ay) If Under 1 Year If Under 24 H		Year) 9. Birth	nplace (State or Foreign
ı,	Director		Usual Residence of Decedent	13		Sept. 21	0,1930 11/6	aryland
	aryland show	_	10a. State 10b. County	10c. City, Town o	r Location			10d. Inside City Limits
	the Ma 28a-f	ecto	Maryland N	4 Ba	10f. Zip Code	1.0	- 0%	1 Yes 2 No
	death with the Maryland ms 23s or 28s-f ehow r must be rodiffed at	<u>=</u>	GOH WLOX	ington St. #13	21253	10	g. Citizen of What Cou	A
	r deat	Funeral Director	11. Marital Status	Armed Forces?	3. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - Amer Black, White	
36	within 72 hours after ene. then "neturel", or Ite he Medical Exandre	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 □Yes 2 TNo If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:	,	Specify: D	leak
Maryland 21215-0036	72 hou	eted	15. Decedent's E (Specify only highest gr.	ducation 16a. De	ecedent's Usual Occupation live kind of work done during most of w	orking 1	6b. Kind of Business/I	ndustry
121	within ene. then *	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	e. po NOT use retired)	-	0,00	Homo
1d 2	e filed Il Hygir other	Be Co	17. Father's Name (First, Middle, Last		18. Mother's Na	ame (First, Middle, M.	aiden Sumame)	Home
ylar	should be nd Mental marked o	To E	Carey L.	Craia	Geo	rgiann	a Ru	stin
Mar	d 2 sh th and 7 is m treum		19a. Informant's Na e/Relationship (Type, Print) 19b. M	ailing Address (Street and Number or F	Rural Route Number,	City or Town, State, Zi	p Code)
	s 1 and if Health item 27 other tr		20a. Method of Disposition	- comptent	sposition (Name of crematory or other place)	Date 20	Oc. Location - City or T	own, State
Baltimore,	Page ment c ent: If ury or		1 ■ Burial 2 □ Cremation 3 □ 1 4 □ Donation 5 □ Other (Special	Removal from State A /1 1	Zinn 6/2	8/2004 1	ansdo	wne. Md
Balt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23s or 28a-f ehow eny injury or other treumatic event, the Medical Examina Investigated to once.		21. Signature of Funeral Service dice	Ise Q Q	22, Name and Address of Facility	cs Fune	eral Ham	e
			23a. Party Enter the dispase, or com	plications that caused the death. Do not one cause on each line.	enter the mode of dying, such as cardia	Aue, Bac or respiratory arres	alto. Md.	21216 Approximate
	Physician		Immediate Cause (Final disease or condition		cardiovascular			Interval Between Onset and Death
7	/Medical Examiner		resulting in death)	Due to (or as a consequence of):		Dongen		
		e	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence of):				
	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events	C			Į.	
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68760,	fficate g phys	edical		d				
Вох	eath cert	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 □Ectopic pregnancy		23d. Date of deliv	•
0	law requires that the death cert as been signed by the attendin 2 should be detached for use	Physician/M	in the past 12 months? 1 ☐ Yes 2 X No 9 ☐ Unknown		5 Other (specify)		Month	Day Year
Ω_	es that the de igned by the a be detached	by Ph	Part II. Other significant conditions of	ontributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribute to t	he cause of death?
ords	w require been sig should b					1 ☐ Yes	2 ☐ No 3 ☐ Prot	bably 4XIUnknown
Records,	e law r has be je 2 sh	ompleted				24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
Vital F	Thate ate	e Cor	25. Was case referred to medical			performe 1X Yes 2		2□ No
f Vi	d is	To Be	examiner? 1 XYes 2 No	Hospital: 1 Inpatient 2 ER/Outpat	045	ath <i>(Check only one)</i> Home 5 \(\subseteq \text{Residence}	ce 6 ther (Specif	(v)
n of	ng Ater Inen		27. Manner of Death 12 Natural 5 Pending	28a. Date of Injury 28b. Time (Month, Day Year) Injur	of 28c. Injury at Work?	28d. Describe how	****	" at scene
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Div	s after s after al Dire	Certification:	4 Homicide determined	building, etc. (Specify)	stroot, ractory, office	City or Town,	State)	n Addie Namber,
	To the Hospitel or Attendi within 24 hours after death. To the Sunerel Director; A completely filled in by the for	edical ((Check only 2 Medicel Exar	ysicien: To the best of my knowledge, deniner: On the basis of examination and/or	eath occurred at the time, date and place investigation, in my opinion, death occ	e, and due to the causurred at the time, date	se(s) and manner as s	tated.
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and mailler stated.	29c. License number		. Date signed (Month,	
	- 2 = 0		1 Zahim	ich Ali	O.C.M.E.		ine 18, 200	
	7			completed cause of death (Item 23a) (Typ	e, Print)			-
	Sta	te.	31. Date filed (Month, Day, Year)	32. Registrar's Signature	111 Penn Street,	Baltimore	e, Maryland	21201
	Registr		JUN 2 5 2004	Sexure &	Sports			

			i icasc i	State of Maryland /	Department of I	Health and Me	ental Hygien	e	
		•	For State	State of Maryland /	Certificate of		Reg. N	200L	20086
			Registrar 1. Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death
	Physicia		Henry Ne	1 17			Month D	Year Year	103gm
	/Medic Examin		4a. Facility Name (If not institution, give		4b. City, Town,	or Locetion of Death	4	c. County of Death	
1	_ Admin		721 E Biddl	e Street	Bal				
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs. last bi	Months Days		3. Date of Birth (Month, Day, Yea	9. Birthr	place (State or Foreign entry) *
	Director	· ·	カアピーメザーコメライ	8/	Yrs.		3/14/1		ginja
	and ww	ŀ	Usual Residence of Decedent 10a. State 10b. County	10c. City, Tov	vn or Location				10d. Inside City Limits
	danyl f sho is 1 s	0	MARyland	B	alto.				1 Yes 2 No
	the 28a-	rec	10e. Street and Number	10	10f. Zip Code		10g. C	Citizen of What Cou	ntry?
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	death	ner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of	Hispanic Origin? (Spec oan, Mexican, Puerto R	ify Yes or No-	14. Race - Americ Black, White,	
9	after or Ite	T.	1 ☐ Never Married 2 ☑ Married	1 ☐ Yes 2 ☑ No If Yes, Give	1 □ Yes 2 No			Specify: R	Lacic
215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f show the Medical Evantinat must be notified at	d b	3 Widowed 4 Divorced	Year or Dates:			1405	0.	
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	filed Hygi other ent, I	Ö	17. Father's Name (First, Middle, Last)		0	18. Mother's Name		an Sumame)	
an	Mental Mental arked c	To Be	Ned Comers			Betsy	1		
Maryland	Star E		19a. Informant's Name/Relationship (T)		b. Mailing Address (Stree	t and Number or Rural	Route Number, City	or Town, State, Zip	Code)
Ž	1 and 2 Health a em 27 is		ELIZAbeth Con	ler (wife)	721 E Bio	idle str	eet B	alto, Md	.21213
ore	of He of He litem		20a. Method of Disposition 1 ☑ Burial 2 ☑ Oremation 3 ☑ f	cemete	of Disposition (Name of ery, crematory or other pla	Da	1 1	Location - City or To	own, State
Baltimore	Page nent o ant: If ury or		'4 □Donation 5 □ Other (Specify	MARY	Land Nat'L	PK. 6/22	/ /	aurel,	MD.
alt	permit. Pag Department Important: any injury c		21. Signature of Funeral Service Licens	888	22. Name and Addr	ess of Facility	39 N. BROC	adivey	21213
_	202 2 2		1 Jeff	nelex	Miller & 1.	netrofololar	· Chape	- Bal	to. mol
			23a. Part Enter the disease of comp shook, or heart failure. List only of	ne cause on each line.	not enter the mode of dy	ing, such as cardiac or		2000	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a Metanta	11c Pros	sicele	Cuscii	nong	1 year.
	/Medical Examiner		Toolaning wir double)	Due to (or as a consequence	of):				
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	ie death the atten hed for u	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of death 9☐Unknown	5 Other (specify)			Widitii	Day Tour
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Records,	w require been sign	Completed					24a. Was an	24h Word aut	opsy findings available
360	e la has	ם					autopsy performed?	prior to co	mpletion of cause of
	ician: Th certificate rector, pag		of Manager Constant			OC Division of Death	1 Yes 2	1 ☐ Yes	2 No
of Vital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/O	Sutpatient 3 DOA O	26. Place of Death ther: 4 Nursing Hom		6 □Other /Speci	fv)
of		υ: To	27. Manner of Death		Time of 28c. Inju		8d. Describe how in		97
Division	Attending F r death. ector: After by the funera	atioi	Natural 5 Pending 2 Accident investigation			Yes 2 □No			
vis	Atte er de ecto by th	tifica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, the building, etc. (Specify)	farm, street, factory, office	28	8f. Location (Street and City or Town, Sta		al Route Number,
	tal or rs afte al Dir ed in	Certification:		Danising, and (apara),					
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	edical	(Check only 2 Medical Exam	vsician: To the best of my knowledginer: On the basis of examination a	nd/or investigation, in my	opinion, death occurred	d at the time, date a	ind place, and due t	o the cause(s)
	the hin 24 the F	Medi	one) 29b. Signature and title of certifier	and manner stated.	20c Licer	nse number	29d F	Date signed /Month	Day, Year)
	Neith Con Con Con Con Con Con Con Con Con Con	-	250. Signature and title of certifier	Ω_{ij}	Da	30601	200.	1110 21	2004
			\$	VVIII	(Type Print)			11200	10 1
	A		30. Name and address of person who o	and manner stated. completed cause of death (Item 23a) 32. Registrar's Synature	400 Erdn	an Aven	we Bo	ilhmox	Maylad 21219
	Sta	te	31. Date filed Month, Bay 5'ea 2004	632. Registrar's Synature	breede				•
	Regist		JUN 2 5 2004	Janes No.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death LUSTER VILLIAM 004 4a Facility Name (If not institution, give street and number) County of Death OSPITOL ank Sa 9 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Gountry) 1° € M 2 □ F Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MARYLAND BALTIMORE BALTIMORE 1 ☐ Yes 2 📉 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? RD, UNITE 21 HARDEL SA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 1 □ Yes 2* No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: WHITE Specify 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) >RIVER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) DALTIMORE MD 21236 20b. Place of Disposition (Name of cametery, crematory or other place) ILDRED 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State DUDON PARK CEMETERY CATONSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 6/28/04 21. Signature of Funeral Service Licensee 22. Name and Address of Facility EVANS CHAPEL OF MEMORIES 8800 HARFORD RD, PARKVILLE, MD 23a. Part1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or head failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death H Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unsease or injury that initiated events Due to (or as a consequence of): Cardio My fathy cfo For resulting in death) Last D e to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 4 Unknown 3 Probably 1 ☐ Yes 2 ☐ No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed 1 Yes 25. Was case referred to medical examiner?

12 Yes 2 \(\subseteq \) No

Physician /Medical Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed

use as the burial-transit

attending physician and

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is been signed by the should be detached

this certificate has been

After

death.

within 24 hours after death To tha Funeral Diractor:

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funeral director,

the

filled in by

Medical Certification: To

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

ö

or flams 23a

Pages 1 and 2 should be filed within 72 hours after

and Mental Hygiene.

Department of Health Important: If itam 27

any injury or other traumatic avant, the Modical Examiner must be multiple at once.

Completed by Funeral Director

Be

Examiner Physician/Medical IF FEMALE ò Be Completed

27. Manner of Death

1 Natural
2 Accident

3 ☐ Suicide

29a. Certifier (Check only

4 - Homicide

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Inpatient

28a. Date of Injury (Month, Day Year)

2 No

26. Place of Death Check on one Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

onel 29b. Signature and title of equilier

29c. License number

29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

rive Bal

State Registrar

31. Date filed (Month, Day, Year) JUN 2 5 2004

5 Pending

investigation

determined

6 ☐ Could not be

La Pobee 9000 Frank 32. Registrar's Signature

Sayar

2 ER/Outpatient 3 □ DOA

28b. Time of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For the Registrar AMEND TTEM #5 PER FH G836 10/91/1/1964 tempf Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 6: 25 PM 2004 JANET LEE COLUMBIA /Medical 4c. County of Death 4a. Facility, Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** ortt wws If Under 24 If Under 1 Year Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days Min 1 □ M 2 X F 71 Director 02-08-1933 Baltimore, MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or Itams 23a or 28a-f show 1 Yes 2 No MD Anne Arundel Brooklyn Park by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 603 Cromwell Street USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) Cotlege (1-4or 5+) Homemaker Own Home 12 . Pages 1 and 2 should be filed vittent of Health and Mental Hygie tant: if Item 27 is marked other talury or other traumatic event, it 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Soaper Bryant 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 603 Cromwell Street Brooklyn Park, MD 21225 <u>Vincent Columbia Sr. / Husband</u> 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition June 28, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or Glen Burnie, MD * 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Memorial 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral Home PA Þ 加ててつ 1 Second Ave S.W. Glen Burnie, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list nonditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed Due to (or as a consequence of) Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year detached for 4 Pregnant at time of death 5 Other (specify) the 9 Unknown o 9 Tillaknows ģ Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 6-Imm robably 4 Unknown 2 🗆 No 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2DANO certificate 2 1 No 1 Yes Vital o the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1- Inpatient Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA of 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred T Satural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide hours after within 24 hours a To the Funerel I indeptifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifie Medical 29b. Signature and (itte of certifier 29d. Date signed (Month. Day, Year) who completed cause of death (Item 23a) (Type, Print) VV

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

JUN 2 5 2004

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1- State AMEND ITEM #5 PER FH G834 8/18/PON/figate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** DANIEL CI CCHINI 128 PM 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 13a Himone If Under 24 Hrs. prial 140 If Under 1 Year 8. Date of Birth (Morth, Day, Year) 9. Birthplace (State or Foreign Country)
DELAWARE 6. Sex 121 M 2□F Age (In Yrs. last birthday) 217-62-3027 Funeral Days Hours Yrs Director Usual Residence of Deceder the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 20 No MIS Be Completed by Funeral Director BALTI MORE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 3830 21220 or Iteme 23a filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: white 3 Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiane Important: If fem 27 is marked other than ony injury or other traumatic aven? Elementary/Secondary (0-12) College (1-4or 5+) Mochanic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 10 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) hini-Drother 100 DALTIMORE d. Baltimore, 20b. Place of Disposition (Name of cometery, grematory of other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State FORESTHILL MD * 4 □ Donation 5 □ Other (Specify) 21. Signature of/Funeral Service Licensee 22. Name and Address of Facility imoRE, 23a. Part. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure/ List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Uncal Herriation **Physician** hours /Medical Due to (or as a consequence of): Left Middle Cerebral Artery Stroke duns **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner days rsicien and e burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Laft Internal Carotil Artery Dissection Due to (or as a consequence of): Box 68760 Left Internal Curatid Altery Stunosis Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? λq Records, 3 Probably 4 Sonknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 No 1 🗆 Yes 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{Specify} \) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Sil 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 ☑Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a
To the Funeral D
completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and fittle of certifier Anderson, Pho, MD RES-000 June 19, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W:((: am S. An Jersan, Pho, Mo, 600 Na/th Wolfe Street, Baltimore, MO 21287 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 2 5 2004 Registrar South

			1 - For State Registrar	State of Maryland / Depa	artment of Health and rtificate of Death		iene	00000
		**	1. Decedent's Name (First, Middle, Last)			2. Date of Deat	h 6004	3. Time of Death
	Physici /Medio		DAVID EDWARD CRO	OOK. JR.		JUNE	21, 2004	5:00p. M
	Examir		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Dea		4c. County of Death	
			1548 Wadsworth Wa	у	Baltimore City		N/A	
	Funeral		5. Social Security Number 6. Sex	IM 2□E	If Under 1 Year If Under 24 Hr Months Days Hours Mir	. (Month, Day,	Year) 9. Birthr	place (State or Foreign (NY) (YLAND)
	Director		218-28-5351 X	72 Yrs.		11/3/31	MAH	(YLAND
	land ow		10a. State 10b. County	10c. City, Town or Lo	cation		1	10d. Inside City Limits
	Many Frah	ţō	MD N/A	BAL	TIMORE			1∭Yes 2□No
	n the	Director	10e. Street and Number		10f. Zip Code	10	Og. Citizen of What Cour	ntry?
	23a (a	1548 WADSWORTH WA	ΑY	21239		USA	
	r dea	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (f Yes, specify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Americ Black, White,	
36	s afte	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 🕅 No If Yes, Give	1 ☐ Yes 2 🎇 No Specify:		Specific	
21215-0036	within 72 hours after death with the Maryland jiene. r than "natural", or Items 23a or 28e-f show the Medical Examir er mart be notified at		3 ☐ Widowed 4 🌠 Divorced 15. Decedent's Edu	Year or Dates:	dent's Usual Occupation		WI- 16b. Kind of Business/In	HITE
15	nin 72 n ne	Completed	(Specify only highest grade	e completed) (Give	kind of work done during most of wo DO NOT use retired)	orking	Tob. Kind of Business/in	Justry
212	d within giene. or then "	mo	Elementary/Secondary (0-12)	College (1-4or 5+) + YEARS CON	TRACTOR		PLUMBING &	HEATING
pu	be filed ntal Hygid od other	Be C	17. Father's Name (First, Middle, Last)			me (First, Middle, N		111111111111111111111111111111111111111
yla		To	DAVID EDWARD CROOK			TA WEEKS		
Maryland	- a = =		19a. Informant's Name/Relationship (Ty, MICHAEL CROOK/SON		ng Address (Street and Number or F			Code)
	1 and 2 Health	1	20a. Method of Disposition	20b. Place of Dispo		TIMORE, M		2011
Jor	ages nt of I		1X Burial 2 □ Cremation 3 □ R	comoton, oron	natory or other place)		OOD ATTAL ME	
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 eny injury or other once.		4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service License		Name and Address of English		OODLAWN, ME	
Ba	Dermi Depa Impo eny ii	l, J))		11		n Funeral Ho	
	As Assessment		23a. Part Enter the disease, or compli	cations that caused the death. Do not ente	8521 Loch Raven or the mode of dying, such as cardia	ic or respiratory arre	st,	Approximate
	Physician	1 2	Immediate Cause (Final disease or condition	Mula A	DIA 7	V PAD	mical.	Interval Between Onset and Death
	/Medical		resulting in death)	ue to (or as) consequence of):		VI / ICC		Hygy
B	Examiner		Sequentially list conditions, if any, leading to immediate					
J	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):				
Š	and al-trar	хап	that initiated events resulting in death) Last	Due to (or as a consequence of);				
58760,	icate be executed physician and s the burial-transit	dlcalE						
89	ificate g phy as the	Ψ:						
Вох	death certif e attending d for use a	Z	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 3□	IC-14-1-		23d. Date of delive	ry
	deat	sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No		Ectopic pregnancy Other (specify)		Month	Day Year
P.0	that the death certific ed by the attending p detached for use as	Physiclan/M	9 Unknown					
	Se C 0	by	Part II. Other significant conditions con	wiburing to death but not resulting in the un	iderlying cause given in Part I.		acco use contribute to th	
ō	w equir been si should t	eted				1 Tes	s 2 No 3 Proba	ably 4 🗍 Unknown
Records,	e faw has t	Completed				24a. Was an autopsy perform	prior to con	osy findings available appletion of cause of
	ian: Th rtificate ctor, pag		25 111			1□ Yes 2	☑ No 1 ☐ Yes	2 □ No
Vital	- S 0	o Be	25. Was case referred to medical examiner?	lospital: 1 Inpatient 2 ER/Outpatient	Other	ath Check only The		
of	g Phys er this eral di	-	27. Manner of Death	28a. Date of Injury 28b. Time of	28c. Injury at Work?	28d. Describe hov	nce 6 Other (Specify vinjury occurred)
io	uttending I death. ctor: After y the funer	atlo	Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury	Work? M 1 □ Yes 2 □ No			
Division	or Atterder de Directo	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, stree building, etc. (Specify)	eet, factory, office	28f. Location (Stre City or Town,	eet and Number or Rural	Route Number,
	itel o irs aft rs! Di						·	
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	edical	(Check only 2 Medical Examir	sician: To the best of my knowledge, death ner: On the basis of examination and/or inv	occurred at the time, date and place estigation, in my opinion, death occ	e, and due to the cau	use(s) and manner as sta e and place, and due to	ated. the cause(s)
	o the othe omple	Med	29b. Signature and title of certifier	and manner stated.	29c License number		d. Date signed (Month, D	
ı	- ≥ - 3		1//////////////////////////////////////	man	1)201		10/221	nin
	n		30. Name 2 d address of person who co	mple at cause of death (Item 23a) (Type,	10000	1 4	100/1	100
			F. SAUZARO,	W 3346 1	uper Mil	Lel .	Phoenip	Ma
	Sta Registr		31. Date filed (Month, Day, Year) JUN 2 5 2004	32. Registrar's Signature	souls!		E	71131

			1	For State of Marylan	-	artment of H			giene Reg. No.		20091
		Physicia	n	Decedent's Name (First, Middle, Last) Milton Theodore Carrow				2. Date of Dea June 24	Da.,	Year	3. Time of Death 8:55 A. ^M
		/Medica Examine		a. Facility Name (It not institution, give street and number) Gilchrist Hospice		Towson	Location of Death			of Death	
		uneral irector		Social Security Number 214 26 5662 6. Sex 7. Age (<i>In yrs.</i> 71	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day 12/20/	7932	9. Birth Cou Mar	pplace (State or Foreign intry) Yland
	laryland	show		State 10b. County 10c. Cit Rd 10c. Cit 10c.	y, Town or Lo osedal	ocation E		-			10d. Inside City Limits 1 ☐ Yes 2 🐼
	death with the Maryland	a or 28a-1 1 be notifi	Funeral Director	0e. Street and Number 1606 Chesaco Avenue		10f. Zip Code 21237			10g. Citizen of V USA	Vhat Cou	untry?
	036 urs after death	Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Mudical Exportrer must be notified at once.	2	1. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U Armed Forces? 1 Never Married 2 Married If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes 2 XNo	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)	Blac	e - Amer ck, White hite	
	215-0(thin 72 hou	an "natur Mudical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	edent's Usual Occupa e kind of work done o DO NOT use retired,	ation furing most of worki)	ing	16b. Kind of Bu		
	Maryland 21215-0036 at 2 should be filed within 72 hours after the and Marial Horisone	c event, the	Be	7. Father's Name (First, Middle, Last) Theodore Carrow	Truck	Driver	18. Mother's Name	e (First, Middle,	Maiden Suman		eight Co.
	Mary!	27 is mark rtraumati	L L	19a. Informant's Name/Relationship <i>(Type, Print)</i> Joyce Carrow Wife		ing Address (Street a	and Number or Rura	il Route Numbe	r, City or Town,		
	Baltimore,	nt: if item iry or othe		Oa. Metrod of Disposition	cem etery, cre	osition (Name of matory or other place Cemetery		2004	20c. Location - Baltimo		
	Balti permit.	tmporte any inju		21. Signature of Funeral Service Licensee	1	2. Name and Addres 211 Chesa	ss of Facility Cva co Avenue	ch/Rose Roseda	dale Fu le, Mar	nera ylan	1 Home ad 21237
And I		Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consec	u Ce	. 1	g, such as cardiac o		rest,		Approximate Interval Between Onset and Death
seed Me	760, 19 te be executed	been signed by the attending physician and should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consect of the consect of							
Clerk	Records, P.O. Box 68 The law requires that the death certifical	the attending pheed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3(□Ectopic pregnancy □ Other (specify)				te of deliventh	very Day Year
3004	rds, P.	n signed by uld be detac	d by Ph	Part II. Dther significant conditions contributing to death but not re	sulting in the u	underlying cause give	en in Part I.	\vee	pbacco use cont res 2 □ No		the cause of death?
43	Reco	s certificate has bee irector, page 2 sho	Completed by					24a. Was autop perfo 1 Yes	rmled?	Were aut prior to c death? 1 Yes	topsy findings available completion of cause of 2 No
iene of	Division of Vital Records, P.O. Box	.00	To Be	25. Was case referred to medical examiner? 1	ER/Outpatie	of 28c. Injun Work	y at k?	me 5 Resid	ne) dence 6 X Oth now injury occur		HOSPICE
CK	Division al or Attendir	within 24 nouts after deart. To the Funeral Director: After the completely filled in by the funeral	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At homicide 28e. Place 28e	nome, farm, s'		Yes 2□No	28f. Location (S City or Tov		er or Ru	ral Route Number,
0853	ne Hospit	n 24 nours na Funera	Medical (29a. Certifier (Check only one) Medical Examiner: On the basis of examinand manner stated.	owledge, dea ation and/or i	nvestigation, in my o	pinion, death occur	red at the time,	date and place,	and due	to the cause(s)
0	Toti	To 1	Σ	29b. Sgnature and fittle of certifier		29c. Licens	8303 S8303		June June	d (Month	7. Day, Year)
		0		30. Name and address of person who completed cause of death (Ite	m 23a) (Type	Charles	St Bal	hmore	e mo	212	04
	Dura	Sta Registr	ar	JUN 2 5 2004	Cool						
	SUMU	17 Rev 1/2	υυ I		ORIGIN	IAL					

			State of Maryland / Department of Heal 1- State Amend Item #10b per Th G833 //1104 tas Registrar AMEND ITEM #19a PER INF G833 9/11/24ta of Dea	Ith and Me	ntal Hygie	ne "2001	20000
	Q.		1. Decedent's Name (First, Middle, Last)		. Date of Death		3. Time of Death
	Physicia Medic/		Patricia Ann Drummond		Month June 2	Day Year 2, 2004	I I I I I A LA
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Loca			4c. County of Dea	
			Chiv. of Maryland Medical Center Baltimo 5. Social Security Number 6. Sex 7. Age (In vis. last birthday) If Under 1 Year If U				ore City
	uneral irector	1		ours Min.	Date of Birth (Month, Day, Ye	ar) 9. Bii	rthplace (State or Foreign ountry)
			Usual Residence of Decedent		7 0 17		10
ırylan	show	.	10a. State 10b. Count Carroll 10c. City, Town or Location				10d. Inside City Limits
e Me	8a-f	ecto	MID Halltmare Reisterstown				1 ☐ Yes 2 ☐ No
with t	a or i	Ö	34 Ob Blueberry Lane 2113	(_	10g.	Citizen of What C	ountry?
death with the Maryland	ms 23	Funeral Director	11 Marital Status 12 Was Decedent Ever in U.S. 13, Was Decedent of Hispani		y Yes or No-	14. Race - Am	erican Indian,
afte	or marked other than "naturel", or liams 23a or 28a-f show marked other than "naturel", or liams 23a or 28a-f show matic avant, the Medical Examiner must be notified at	/ Fur	1 Never Married 2 Married 1 Tes 2 No	exican, Puerto Ric pecify:	ćan, etc.)	Black, Whi	
Ind 21215-0036 be filed within 72 hours after that Haviene	ural',	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		1.0		Slack
7 i	r "nai	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during life. DO NOT use retired)	g most of working	160	. Kind of Business	s/Industry
d with	ir tha	mo	Elementary/Secondary (0-12) College (1-4or 5+) College (1-4or 5+)		G,	oodyear	Inc
yland 212 Juld be filed with	d oth avant	Be (17. Father's Name (First, Middle, Last)	Mother's Name (F	irst, Middle, Maid	ten Sulmame)	
S Page	narke	7	Solomon Hinton C	elia			
Man de st	3 2		19a Informant's Name/Belationship (Type Print) GOURTNEY L. DRUMMOND JR. (HUSBND) 34 Cb. Blucke. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Number or Hurai H	O L	y or Town, State,	Zip Code)
re, N s 1 and f Health	itam 27 othar t		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	9 20c.	Location - City or	Town, State
altimore, mit. Pages 1 ar	int: If		1 TOURIAL 2 Cremation 3 IHemoval from State -	1			· ·
Salt Frmit.	Important: If it any injury or o		21. Signarure of Funeral Service Dicensee 22. Name and Address of F				
n 88	2 2 2 3		Mode Kely Vancho Core	exne tun	ressevit	es , 872	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line.	ch as cardiac or re	espiratory arrest,		Approximate Interval Between Onset and Death
le:	/sician ledical		Immediate Cause (Final disease or condition resulting in death) Necrotizes tasciffs Due to (or as a consequence of):				
	aminer		Ful Stage Penal Disease	č			
TO TO	.=	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying				
ecute	and -trans	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Atrial Fibrillation Due to (or as a consequence of):				
8760, cate be executed	sician and burial-transit		Due to (of as a consequence of).				
	the	edicai	d				
Records, P.O. Box 6 The law requires that the death certiff	igned by the attending pose detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy			23d. Date of de	livery
O. Be deal	the att	sici	in the past 12 months? 1			Month	Day Year
P.O	ad by	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in F	Part I	23a. Did tobaco	co use contribute t	o the cause of death?
ds,	ld be	d by			1 ☐ Yes		robably 4 Unknown
Division of Vital Records, for Attending Physician: The law requires talled clearly	s been si	Completed		[24a. Was an	24b. Were a	utopsy findings available
The la	cate has I	шо			autopsy performed 1 Yes 2 2	? death?	completion of cause of
/ita	: After this certificate funeral director, pag	Bec	examiner:	Place of Death (C			
of V	this ci	은	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 [6 ☐ Other (Spe	ocify)
ding	After	tion:	27. Manneyof Death 1 Dratural 5 Pending (Month, Day Year) Injury 28b. Time of Work? 2 □ Accident investigation M 1 □ Yes		f. Describe how in	ijury occurred	
VISION Atten	Diractor: ,	ifica	3 ☐ Suicide 6 ☐ Could not be				ural Route Number,
Division of the state of the st	al Dira	Certification:	4 ☐ Homicide determined building, etc. (Specify)		City or Town, St.	ate)	
Division of Vital To the Hospital or Attending Physician: Within 24 hours after cleath	To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, da 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, and manner stated.	ate and place, and n, death occurred a	due to the cause at the time, date a	(s) and manner as and place, and du	s stated. e to the cause(s)
To the	To the	Me	29b. Signature and titleyof certifier 29c_License num	nber	29d. I	Date signed (Mont	th, Day, Year)
il)		July my MD	639	7	une 22,	2004
Cod	ltrey MD		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Univ. of Mary Land Medical Center 22 S. Greene St.	R. 14:			
	Sta		Univ. of Mary land Medical Center 22 S. Greene St. 31. Date filed (Month, Day, Year) 32. Registrar's Signature Space Space 111N 2 5 2004	Dallimil	9	01201	
	Registr		JUN 2 5 2004 Senera & Sparks				6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** June 22, ' 2004 1:03 P M Margaret A. Dyke /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Annapolis Anne Arundel 1695 Crownsville Road 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 F Days Hours Min 6-14-1952 52 Yrs. Maryland 213-64-2453 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. Count 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2XXIIIo Blount Greenback Tennessee Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 37742 5356 Morganton Rd. or Itama 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2XNo White Specify: 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) Cotlege (1-4or 5+) Federal Government 2 years Administrative Assistant marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event Leslie C. Wells Thelma Anne Farrell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5356 Morganton Rd., Greenback, TN 37742 Ray Dyke/ Husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Grandview Cemetery 6-26-04 Maryville, Tennessee 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility George P. Kalas Funeral Home once 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) cascinoid cancer Metastatic **Physician** /Medical Due to (or as a consequence of) **Examiner** S—pentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and s the burial-transit certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Year for Month Day 4 Pregnant at time of death 5 ☐ Other (specify) o. the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 🗌 Yes Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one examiner? Parent's Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Sign Sign 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. within 24 hours after death.

To the Funeral Director: A completely filled in by the fu € ☐ Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, streel, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 6 the Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kathleen Kemmer, M.D. 900 Bestgate Rd., Suite 300, Annapolis, MD 21401 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Ē	04000		For State Registrer	of Maryland / Depa Cer	artment of He		ntal Hygie	2001	20094
1	Physicia	an	1. Decedent's Name (First, Middle, Last)				. Date of Death Month	Day Year 22, 2004	3. Time of Death 11:13 A M
	/Medic Examin	•	Lizzie Ennis 4a. Facility Name (If not institution, give street and 3009 Ferndale Ave.	number)	4b. City, Town, or Lo	ocation of Death	June	4c. County of Dea	
2	Funeral Director		5. Social Security Number 6. Sex 1 M 20	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year	If Under 24 Hrs o	Date of Birth (Month, Day, Ye) 9 / 1 5 / 1	9. Bi	rthplace (State or Foreign ountry)
	D D		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits
	r 28a-f s	Director	MD N/A 10e. Street and Number	Baltim	Ore 10f. Zip Code		10g.	Citizen of What C	1 M Yes 2 □ No ountry?
	ath with	raiD	3009 Ferndale Ave		2120			USA	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23c or 28e-f show other traumatic event, the Medical Exament must be routified at	by Funeral	1 Never Married 2 Married 1 Yes	es 2□No	Was Decedent of Hisp f Yes, specify Cuban, 1 ☐ Yes 2X No	panic Origin? (Specit Mexican, Puerto Ric Specify:	fy Yes or No- can, etc.)	14. Race - Am Black, Whi	ite, etc.
Maryland 21215-0036	within 72 hou ene. than "nature the Medical E	Completed	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) College	(Give life. I	dent's Usual Occupation kind of work done dur DO NOT use retired)	on ring most of working		. Kind of Business	
27	e filed wi al Hygien other th vent, the		12 years 17. Father's Name (First, Middle, Last)	Hous	e Wife	8. Mother's Name (/		omestic	· —
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lary	2 should be and Mental Is marked sumatic ev	-	19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and				
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HOL	Pages ent of nt: If It		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal fi 4 ☐ Donation 5 ☐ Other (Specify)	com State Crowns V	natory`or other place) rille	06/28	3/04 An	ne Arur	del, MD
Baltimore,	permit. Pages 1 an Department of Heal Importent: If Item 2 any injury or other once.		21. Signature of Fue of Service Licensee	well 4	Name and Address 600 Libe	of Facility Howe	ell Fun	eral Ho	ome co.,MD 2120
	* S		23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause	nat caused the death. Do not ent on each line.	er the mode of dying,	such as cardiac or r	espiratory arrest,		Approximate Interval Between Onset and Death
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Vita	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?		Other	26. Place of Death (
	Phys	n; To	27. Manner of Death 28a.	I ☐ Inpatient 2 ☐ ER/Outpatien late of Injury Month, Day Year) 28b. Time of Injury	IL 3LIDUA	4 Nursing Home	5 ☐ Residence d. Describe how i		ecify) at scene
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	To the Hospitel or Attenwithin 24 hours after deating the Funerel Director: completely filled in by the	edical C	(Check only 2 Medicel Examiner: On t	o the best of my knowledge, death he basis of examination and/or in- manner stated.	h occurred at the time, vestigation, in my opin	date and place, and ion, death occurred	d due to the cause at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
	To the Vithin 2 To the complet	Me	29b. Signature and title of certifier		29c. License n	number	1	Date signed (Monume 23, 2	
	/		30, Name and address of person who completed	cause of death (Item 23a) (Type,					
	5		Tasha Z Greenberr	F1. 0	111 Penn S	Street, B	altimore	, Maryla	nd 21201
	Sta Registr		31. Date filed (Month, Day, Year) JUN 2 5 2004	2. Registrar's Signature					

			For State Registrar			nd / Dep		of H	ealth and I	-	/giene	ible.	
			Decedent's Name (First, Middle	le, Last)			Timoato	01 2	Jean	2. Date of D	Reg. No.	94-	20095
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	/Medic Examin		4a. Facility Name (If not institution		mber)	-	4b. City, To	own, or	Location of Death			y of Death	0.001
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	Funeral		5. Social Security Number	6. Sex		s. last birthday,	If Under 1	Year_	If Under 24 Hrs.	8. Date of Bi	rth		lace (State or Foreign try)
	Director		223-38-6385	1 ☐ M 2 🛛 F	7	2 Yrs.	Months	Days	Hours Min.	May 10	ay, Year) 1932	Vir	ginia
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	aryla shov	-	10a. State 10b. County		100.0	City, Town or L	ocation					1	0d. Inside City Limits
	the Marylan r 28e-f show	ecto	Maryland Harfo	ord	J	oppa							1 ☐ Yes 2 X No
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C.	ter dea Items	Ë	11. Marital Status 1 ☐ Never Married 2 ☐ Mar	Armed Fo	rces?	0.5.	If Yes, specify	y Cubar	spanic Origin? (S n, Mexican, Puert	pecify Yes or No o Rican, etc.)	0- 14. Ha Bla	ce - Americ ick, White, o	
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lar	should be ind Mental is marked o	ToE	Keith Rhudy	Wright					Martha	Louise	Doss		
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\ <u>\</u> 2			Lynn S. Eller	/ Son		2406	Maxa	Mea	dows Lar	e, Fore	st Hill	, MD :	21050
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in G	Page nent o ent: If ury or		1 Surial 2 Cremation 4 Donation 5 Other (S			omers F				26/04	Elk Cr	eek, v	Virginia
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× ×	Attending Physicien: The law requires that the dealh certifica reasth. rdeath. ector: Atter this certificate has been signed by the attending pt by the funeral director, page 2 should be detached for use as to	by Physician/Med	IF FEMALE:	230 If yo out	nome of proor	20001					I		1/
8	attend for us	ian	23b. Was decedent pregnant in the past 12 months?		irth 2 ☐ Fet	tal death 3	Ectopic preg					te of deliver onth	y Dav Year
0	he de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkno	ant at time of	death 5L	Other (spec	:rry)					
A 9.	that the de ed by the detached	Ph	Part II. Other significant condition	ons contributing to de	eath but not re	sulting in the u	nderlving cau:	ise civer	n in Part I	23e. Did t	obacco use cont	tribute to the	a cause of death?
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7 2	Phy r this aral d	-	27. Manner of Death		npatient 2 L of Injury h, Day Year)	ER/Outpatier 28b. Time of		. Injury	4 ☐ Nursing Ho	ome 5 ☐ Resident	dence 6 ∏Oth now injury occur	er (Specity) red	
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\mathcal{E} Division	Atter r dea actor by the	fice	3 Suicide 6 Could	not be 28e. Place	of Injury - At I	home, farm, str hify)	eet, factory, o	office		28f. Location (S	Street and Numb	er or Rural	Route Number.
ä	el or s afte	Certification:	4 Horricide	Buildii	ng, etc. (<i>Spec</i>	iry)				City or Tov	vn, State)		
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	dicai	29a. Certifier (Check only 2 Medical	g Physician: To the	best of my kn	lowledge, death	n occurred at	the time	, date and place,	and due to the	cause(s) and ma	inner as sta	ted.
	ths H in 24 the F plete	9		Examiner: On the ba and mann	er stated.	ation and/or in	vestigation, in	my opi	nion, death occur	red at the time,	date and place,	and due to t	he cause(s)
	With To T	Σ	29b. Signature and title of certifie		_		29c. L	•	number		29d. Date signe	d (Month, D	ay, Year)
			1//	an	1		12))	4731	0	June	20. 20	004
	V		30. Name and address of person		/								
_			Kam Lun AuYeun				ake Dr	., E	Bel Air,	MD 2101	4		
	Sta	-	31. Date filed (Month, Day Year)	A.	egistrar's Sign	ature							
	Registra	ar	JUN 2 5	2004	The state of	de do	selled						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Darnell Eley State of Maryland / Department of Health and Mental Hygiene 04-04070 For State Registrar RJ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 19, ARNELL June 2004 0621 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Maryland General Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 □ M 2 K F 214-58-9413 APRIL 05 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 77 ia marked othar than "natural", or Items 23s or 28a-f shov traumatic evant, the Medical Exonemer must be coulded at 1 Yes 2 □ No Director MARYLAND 10g Citizen of What Country? 10e. Street and Number 10f. Zip Code KECompleted by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1X Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) OWN 1AKER 2 HIGRADE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Int: If item 27 is marked o ELORES JOHA 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) SON RADECKE AVE. APT.A. BALTO, MD. 21206 RMAINE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of I
Important: If its
any injury or of 1X Burial 2 ☐ Cremation 3 ☐ Removal from State ION CEMETERY * 4 □Donation 5 □ Other (Specify) 106 22. Name and Address of Facility BROWN JR, FUNERAL HOME JOSEPH H. BROWN JR, FUNERAL HOME 2140 N. FULTON AVE, BALTO, MD. 21217 TR, FUNERAL HOME 21. Signature of Funeral Service Licenses Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Cane **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of): Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Dav 4□Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Be Completed by ed bluods 1 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 □ No 24a. Was an page 2 autopsy performed? this certificate Yes 2 ☐ No or Attanding Physician: the funeral director, 25 Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 X Yes 2 🗌 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Diractor: After 1 Natural 2 Accident 5 Pending 1 🗌 Yes 2 🗌 No death. investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature a OCME June 22, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature 31. Date filed (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

JUN 2 5 2004

ORIGINAL

unpend item#23a,27,PER ME,C833,7/2/04eg Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death JUNE $200\overset{\text{Year}}{4}$ 17, **Physician** -ARRY 5:21P. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 501 E.PRESTON STREET BALTIMORE If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Sex 1 M 2 ☐ F 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 230-02-246 MARYLand Director Usual Residence of Deceden the Maryland 10b. County 10c. City. Town or Location 28a-f show 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Baltimore Director Md. 10e Street and Number 10f Zin Code 10g. Citizen of What Country? death with ō 21202 USA or Items 23e TON 12. Was Decedent Ever Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) in U.S. 14. Race - American Indian 11, Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 No 2 ☐ Married 1 Yes 200 No Baltimore, Maryland 21215-0036 Specify: þ ack 3 Widowed 4 Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hyglene. ant: If item 27 Ia marked other then? Elementary/Secondary (0-12) College (1-4or 5+) WORKINGWATH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) toster Mildred Edward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mother 719 Heartsdale Rd. Balto Md. 21239 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Cremation 3 Removal from State permit. Page Department of Important: If any injury of 123 4 Donation 5 Other (Specify) 2101 Cemetery 21. Signature of Function ce Licens 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory a sest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acquired Immunodeficiency Syndrome (AIDS) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). The law requires that the death certiticate be executed use as the burial-transit and Due to (or as a consequence of): the attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached tor Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Nother (Specify)} \) SCENE 2 2 🗌 No 1 XYes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Director: Atter 1 Natural 5 Pendina investigation 1 Tyes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) O.C.M.E. JUNE 18,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 BIUCLAH 31. Date filed (Month, Day, Year) Registrar's Signature State JUN 2 5 2004 Registrar

			1 For State	State of Mar		epartmen Certificat			lental Hy	0.0			
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	Funeral Director		5. Social Security Number 6. Sec. 216-42-4355	x 7.Age(]M 2XX]F	(In <i>yrs. l</i> ast birth 84 Yi	Months	Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	7th Year) 19	9. Birthp Cour SC	place (State or Fo	reign
			Usual Residence of Decedent						12/23	7/1313	SC		
	arylan show	_	10a. State 10b. County	1	10c. City, Town						1	0d. Inside City Li	
	Ba-f	Scto	MD N/A		Bal	timore	<u>.</u>					X⊠Yes 2[]No
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lar	uld be denta rrked rrked	To B	Hunter C. O'	Neal				Berth	na Mur	phy			
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Baltimore,	95 = 5		20a. Method of Disposition 1XXX urial 2 ☐ Cremation 3 ☐ R	lemoval from State		crematory or o	ther place	θ)	Date	20c. Location			
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	/Medical Examiner		resulting in death)	Due to (or as a c						-/1	-		
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	rted	nine	if any, leading to immediate cause. Enter Unionlying Cause (Disease or injury	bue to (br as a c	consequence or)	_							
Ć	be execute sician and burial-trans	Examin	that initiated events cresulting in death) Last	Due to (or as a c	consequence of)	:							
8760,	cate be executed bhysician and the burial-transit	dicai		J									
9		Med	IF FEMALE:										
Вох	the death certifii y the attending p iched for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1 Live birth 2	Fetal death	3 □Ectopic pre					te of deliver	ry Day Year	
o.	that the de led by the a detached i	ysic	1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at tim 9□Unknown	ne or death	5 Other (spe	ecify)					zu, rou	
σ.	s that ned by e deta	by Ph	Part II. Other significant conditions con	tributing to death but r	not resulting in th	e underlying ca	ause give	n in Part I.	23e. Did to	obacco use cont	ribute to the	e cause of death?	?
Records,	The law requires that ite has been signed b page 2 should be deta								1 🗆 🗅	Yes 2□No	3 Proba	ably 4 Inkno	own
000	e law requ has been le 2 shoul	piet							24a. Was		Were autop	sy findings availa	able
Œ.		Completed							autop perfo	rmed?	prior to com death? 1 🗌 Yes	pletion of cause	10
Vital	Physician: This certifical director, p	Be	25. Was case referred to medical examiner?	la animalia				26. Place of Death	(Check only o	ne)		1000	
of	Phys this al dii	. To	1 ☐ Yes 2 No	ospital: 1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpa 28b. Tim		-	Nursing Hor		dence 6 □Oth)	
on	Attending I r death. ector: After by the funer	tion	1 Alatural 5 Pending 2 Accident investigation	(Month, Day Yo	ear) Zob. Till		3c. Injury Work	ar ? ′es 2 ⊟No	zad. Describe r	now injury occur	red		
Division	I or Attendi after death Director: A in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury	- At home, farm				28f. Location (S	Street and Numb	er or Rural	Route Number,	-
Ö	tel or A rs after el Dire ed in by	Cert	* LI HOMICIO	building, etc. (Speciry)				City or Tow	m, State)			
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	edicai	(Check only 2 Medical Examin	ician: To the best of n	tamination and/c	eath occurred a r investigation,	it the time	e, date and place, a inion, death occurre	and due to the	cause(s) and ma	inner as sta	ited. the cause(s)	
	o the ithin 2 o the omple	Med	29b. Signature and file of certifier	and manner stated	1.		License			29d. Date signer			
}	- s + ō			mi X	1)	ſ	7	7333		JUNE			
	4	1	30. Name and address of person who co	mpleted cause of death	h (Item 23a) (Ty	pe, Print)						,	
			30. Name and address of person who con				. /	4021	133				
	Sta Registr		31. Date filed NAth 2 a 5 Y 2004	32. Registrar's	Signature	de						-	
	1091311		_	•									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State	State of Marylar	•			-	_	- ·	000	
			Registrar 1. Decedent's Name (First, Middle, Last	1	Cer	tificate of	Death	2. Date of De	Reg. No.	UUL	3. Time of	Death
	Physicia		Michael		(Sarr.	44.0	Month	Day	1 2mc+	13.30	PM
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b_City, Town, o	r Location of De			County of Death		
			The Johns	Hopkins Ho	Spine	BAG	Finiore.	City				
	Funeral Director		5. Social Security Number 6. Se 15 15	X 7. Age (In yrs.	68 Yrs.	If Under 1 Year Months Days	Hours M		y, Year) 193	Cou	nplace (State or untry)	r Foreign
	ס		Usual Residence of Decedent									
	show	'n	10a. State 10b. County		ity, Town or Lo						10d. Inside City	
	28e-f	Director	MD N/A 10e, Street and Number	Ва	ltimore	10f. Zip Code			10a, Citi	izen of What Cou		
	3a or		1936 Mt. Royal Ter	race		21217			-	ted Stat	-	
	death	Funeral	11. Marital Status	12. Was Decedent Ever in U	J.S. 13. V	Was Decedent of H f Yes, specify Cuba	lispanic Origin?	(Specify Yes or No	-	14. Race - Amer Black, White		
36	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Importent: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other treumatic event, I'm Medicul Eraf, a at most ke nutilly of an once.	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1□Yes 2⊠No	Specify:	onto i moderi, otori,		Specify:		
21215-0036	2 hour	ted b	15. Decedent's Edu	cation	16a. Deced	dent's Usual Occup	pation		16b. Ki	Whit ind of Business/l		
215	thin 72 e. an "na! Medic	Completed	(Specify only highest grad Elementary/Secondary (0-12)	le completed) College (1-4or 5+)	(Give life. L	kind of work done DO NOT use retired	during most of v d)	vorking	Hufo	cor		
	filed wi Hygien other th		47 Falk of Alley (Falk Addule Land)	2	Natio	nal Sales		lana (Fina Atiatia		C		
Maryland	d be findal H	Be c	17. Father's Name (First, Middle, Last) Patrick Garrett				Louise	lame <i>(First, Middl</i> e, Yates	Maiden	Sumame)		
ary	should nd Me mark umatic	스	19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Mailin	ng Address (Street		Rural Route Number	er, City o	r Town, State, Zi	p Code)	
	and 2 alth a 27 ls er trei		Mrs. Sharon Garre	t/Wife	1936	Mt. Roya	l Terra	ce, Balti	more	, MD 212	217	
Baltimore,	of He of He If item or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ I	1 ,	Place of Dispo cemetery, cren	sition (Name of natory or other plac	сө)	Date Jun 22	20c. Lo	cation - City or I	own, State	
tim	t. Pages ntment of I rtent: If it		' 4 ☐ Donation 5 ☐ Other (Specify,	Ch	-	ke Cremat			Belt	sville,	MD	
Ba	permi Depar Impo any ir		21. Signature of Funeral Service Licens	86			and Fu	neral Alt		atives altimore	. MD	
			23a. Part. Enter the disease, or como shock, or heart failure. List only	ications that caused the dea						remore	Approximate Interval Betw	
ı	Fnysician		Immediate Cause (Final disease or condition		onav	u E	Emho	dus		4	Onset and D	
	/Medical Examiner		resulting in death)	Due to (or as a consec		10	Jan	olus Chnic	->	_	21	7-
J.		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consec	quence of):	6 00	non	CHIC	101		Syer	AVS
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38760,	icate be executed physician and s the burial-transit	dical		d								
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	ie death certif the attending hed for use a:	Physician/M	in the past 12 months?	1 Live birth 2 Feta 4 Pregnant at time of a 9 Unknown]Ectopic pregnancy] Other (specify) _	· · · · · · · · · · · · · · · · · · ·			Month		'ear
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ecords,	w requir been si should	leted						24a. Was	an	24b. Were aut	opsy findings a	available
$\mathbf{\alpha}$	rhe te ha	ompl						 autop 		prior to condeath?	ompletion of ca	iuse of
Vital	sicien: Certifical	Be C	25. Was case referred to medical examiner?				26. Place of D	eath (Check only o	-	7.2.100	450	
of V	S S	မ	1 Yes 2 No		ER/Outpatien		4 Nursing	Home 5 Resid			ify)	
	ling h. After fune	tlon:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	yat rk? Yes 2 ∐ No	28d. Describe h	now injur	y occurred		
Division	ten leat tor: the	Certification;	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h	nome, farm, str			28f. Location (S City or Tox		d Number or Rui	al Route Numb	ber,
Ö	tel or rs afte el Dir	Cert	4 D Homicide	building, etc. (Speci				City or 70	vii, State,	<i>,</i>		
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	Medical		sician: To the best of my known and the basis of examination and manner stated.								j
	To the within 2 To the complet	Mec	29b. Signature and Atle of Jeuniter	and marrier stated.		29c. Licens	se number		29d. Dat	e signed (Month,	Day, Year)	
	⊢ ≶ ⊢ ō		· NUI/A	7 140		D59	032		lue	21,20	04	
	4		30, Name and address of person who o	ompleted cause of death (Ite	m 23a) Type.	Print)	. 1 46	Street 1	1	2	11	
	1		Moste Yair Cery	32. Registrar's Sign	is Hoger	5/ 60/ (Nolle	sket (21	nonve, /	Taylor	2128
	Sta	ite	31. Date filed (Month, Day, Year)	z. negistrar's sign	L	1						

			For Stete Registrar	State of Maryland /	Department of F Certificate of			ene	20100
			Decedent's Name (First, Middle, La	ist)			2. Date of Death Month		3. Time of Death
	Physici /Medi		agusta	Granis			4	Day Year	6.13 PM
	Examir	er	4a. Facility Name (If not institution, gir	restreet and number)		r Location of Death		4c. County of De	ALIA
	Funeral			Sex 7. Age (In yrs. last t	pirthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day, Y	9. B	rthplace (State or Foreign
	Director		21.18- 2201	10 M 20 4 94	Yrs. Months Days	Hours Min.	9-15-14	Ool	SC SC
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Location				10d. Inside City Limits
	the Maryland r 28a-f show	tor	MD	NA Bo	Himorc				1⊕Yes 2□No
	or 28	Dire	10e. Street and Number		10f. Zip Code		109	. Citizen of What C	
	eath w	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S.	212		ecifu Vas or No-	14. Race - Am	
ထ	rs after death with ", or Items 23a or grainer must be		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No	If Yes, specify Cubi	an, Mexican, Puerto	Rican, etc.)	Black, Wh	ite, etc.
5-0036	72 hours a natural", o	d by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No	Specify:		Specify:	Slack
215-	n 72 h	Completed	15. Decedent's E (Specify only highest gi	ade completed)	 Decedent's Usual Occup (Give kind of work done life. DO NOT use retired 	oation during most of work d)	ing 16	b, Kind of Busines	s/Industry
212	d withingiene.	то	Elementary/Secondary (0-12)	College (1-4or 5+)	Domest			i)omes	stic
bu	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examinal most be netitied at	Be	17. Father's Name (First, Middle, Las				e (First, Middle, Ma	iden Sumame) 😘	nK
Maryland	should Ind Meni	P P	19a. Informant's Name/Relations ip		9b. Mailing Address (Street	Emma		ity or Tourn State	Zin Codol
	s 1 and 2 should be filed within 72 hr f Health and Mental Hygiene. Item 27 is marked other than "natu other treumatic event, the Mcdral		Hattie me Bride	2. / Daughter 4	102.2. Rose co		catons ill	- 41	1715
altimore,	es 1 a of Hea fitem r othe	1 3	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 [20b. Place cemet	of Disposition (Name of tery, crematory or other place			c. Location - City o	r Town, State
ij	Pag tment tant: I		`4 ☐ Donation 5 ☐ Other (Special	m) Drui	d Ridge	6/28		solto. V	
Bal	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than eny injury or other treumatic event, Ite Magnee.		21. Signature of Funeral Service Lice	nsee (c	22. Name and Addre		andallstad		real Service
			23a. Part1. Enter the disease, or con	applications that caused the death. Do	o not enter the mode of dyir				Approximate
	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition	Carline.	inclose to	-il au			Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence	e of):				
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	outed Id ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c.					
90,	cate be executed physician and the burial-transit	i Ex	resulting in death) Last	Due to (or as a consequence	e of);				
38760,	phy phy s the	dicai	•	d					
Box 6	eath certif attending for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy	205-4			23d. Date of de	elivery
	e death	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☑ No	1 Live birth 2 ☐ Fetel deal 4 ☐ Pregnant at time of death 9 ☐ Unknown	th 3 □Ectopic pregnancy 5 □ Other (specify) _	/		Month	Day Year
P.0	that the de led by the a detached t	Phy	9 ☐ Unknown Part II. Dther significant conditions		in the underlying cause giv	en in Part I	23e. Did tobac	co use contribute t	to the cause of death?
ds,	uires tha signed Ild be de	d by	Periphera	Coscular disa	ase	o			robably 4 Dunknown
000	aw requir s been s 2 should	piete	Alzhein	rer's disease			24a. Was an	24b. Were a	utopsy findings available
R	The taw cate has page 2 s	Completed					autopsy performe 1 ☐ Yes 2 🕏	d¥ ∣ death?	completion of cause of
Vita	ysiclan: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?	Hospital:	Oth	26. Place of Death			
Division of Vital Records,	ding Phys h. After this funeral di	n: To	1 Yes 2 No 27. Manger of Death	1 Impatient 2 ER/C	. Time of 28c. Injur	4 🖂 Nursing Ho	me 5 PResidence 28d. Describe how	e 6 Other (Spe injury occurred	ecify)
ion	uttending death. ctor: Afte / the fun	atio	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	on		Yes 2 □ No			
Jivis	or Att	rtific	3 Suicide 6 Could not I 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office		28f. Location (Stree City or Town, S	et and Number or Fi State)	ural Route Number,
	To the Hospital or Attending Physiclan: The law requires that the death certify within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical Certification:	29a. Certifier 1 Certifying P	hysician: To the best of my knowled	ge, death occurred at the tir	ne, date and place, a	and due to the caus	e(s) and manner a	s stated.
	he Ho in 24 h he Fu pletely	edic	(Check only 2 Medicel Exa	miner: On the basis of examination a and manner stated.	and/or investigation, in my o	pinion, death occurr	ed at the time, date	and place, and du	e to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	0 01 0	29c. Licens		29d.	Date signed (Mon	th, Day, Year)
	7		30. Name and address of person who	completed cause of death (from 33)	D19	003	0	107	
	6		Boony on a P.		56 Reis	sterstow,	and of	3. Ho.M	21215
	Sta		31. Date filed (Menth, Day, Year)	32. Registrar's Signature	1 .				
	Regist	ar	JUN 2 5 2004	Warren D	acoula!				

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State of Maryland / Department of Health and Mental Hygiene AMEND ITEM #10e PER FH C842 Cartificate of Death 2. Date of Death Degedent's Name (First, Middle, Last) Month Day Year **Physician** 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** ltimore DIC imox If Under 24 Hrs Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Min. Months Hours 1 M 2 F Yrs 4awa Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10b. County 10c. City, Town or Location 10a State Items 23a or 28e-f ehow the Medical Examiner must be notified at 1 Yes 2 No Completed by Funeral Director LLIMORE 10e. Street and Number GAYLOOD 10g. Citizen of What Country? 10f. Zip Code 21212 216 filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 17 No If Yes, Give 11. Marital Status 1 Never Married 2 Married 21215-0036 ŏ 1 Yes 2 No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced "neturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retiged), 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) BalkingORE I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 12 00 K 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maryland Be 1 and 2 should be Health and Mental Is marked Marion 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) In ormant's Name/Relationship 14530 Health manor noenix MP item 27 MONO other 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, cusmatory or other place)

VANS FUNE LAL CHAPEL — Date Baltimore, 20a. Method of Disposition Important: If its any Injury or of once. 6-23 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) -04 * 4 Donation 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 325 YORK (), TI MONIUM MOZICE EVANS/PFACEFOL ALTERNATIVES FUNDAL CREMATIC
of enter the mode of dying, such as cardiac or respiratory arrest,
Interval Between
Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one pluse on each line. 23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final **Physician** DEMENTIA disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine transit-Due to (or as a consequence of): as the burial attending physician for use as the hirria Box 68760 The law requires that the death certificate be Physician/Medical IF FEMALE If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months?

1 Yes 2 No
9 Unknown 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. the 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😿 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 X No certificate Vital Hospitel or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examine Other: 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 **X**No 1 Inpatient HOSPICE this of funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After t Certification; Division 5 Pending investigation 1 X Natural death. 1 Tyes 2 □No Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 🗌 Homicide within 24 hours a To the Funerel D TC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 3725 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. TARIO MAHMOOD TIMONIUM, MD 21093 82. Registrar's Signature 31. Date filed (Month, Day, Year)
JUN 2 5 2004 Registrar

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s, P.O. B	requires that the d een signed by the hould be detached	by Phys	Part II. Other significant conditions con	ntributing to death but not result	ing in the underlying	cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
Box 687	eath certifi attending p	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 KNo 9 □ Unknown	3c. If yes, outcome of pregnanc 1 □Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown	eath 3 Ectopic			23d. Date of de Month	ivery Day Year
8760,	Physician /Medical Examiner physician and physician and physician and the phital-transit	al Examiner	23a. Part1. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	ack (e)	nde of dying, such as cardia	c or respiratory ar	rest,	Approximate Interval Between Ons.; and Death
Baltimore, Mar	permit. Pages 1 and 2 she Department of Health and Important: If Item 27 is m any injury or other traum 2006.		20a. Method of Disposition 1 🖒 Burial 2 Cremation 3 R. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	SPANDDAUGHTER 20b. Place cent cent cent cent cent cent cent ce	Coe of Disposition (Ninetery, crematory or BUTUS (22. Name a 2/4)	EMETERY 06 - and Address of Hacility 3 A	AVE.X Date / 26-04 20WAJA	3ALTIMORE 20c. Location - City or BALTIMO R. FUNER, BALTO, MI	town, State ORE, MAR. PL Home 0.21217
Maryland 21215-0036	should be filed within 72 had Mental Hygiene. s marked other than "nationatic event, the Medical	To Be Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) O THE RADE 17. Father's Name (First, Middle, Last)		III. DO NOT DO.	ork done during most of wo use retired) MESTIC 18. Mother's Na.	me (First, Middle,		HOME
9800	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked othar than "natural", or items 23a or 28a-1 show or other traumatic event, the Medical Examina	d by Funeral Director	1 Never Married 2 Married 3 XVidowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	13. Was Dec If Yes, sp		7 Specify Yes or No- to Rican, etc.)	Specify:	nican Indian, e, etc.
	Director works 1-8 Waryland	tor	Usual Residence of Decedent 10a. State 10b. County MARVIAND	10c. City,	Town or Location	PALTIMORE	OANA	4,1936 VI	10d. Inside City Limits 12 Yes 2 □ No
*	Physici /Medic Examir Funeral	al er	4a. Facility Name (If not institution, give s 3 4 1 0 1 + 0 L m 5. Social Security Number 6. Sex	AVENUE 7. Age (In yrs. las	st birthday) If Under	TOWN, or Location of Deat ALTIM OF 1 Year If Under 24 Hrs Days Hours Min.	TUNE h ORE 8. Date of Birt	4c. County of Dear	3,100
			For Stete Registrar 1. Decedent's Name (First, Middle, Last)		Certifica	te of Death	2. Date of Dea	th Day Year	3. Time of Death

p			For State Registrar	ate of Maryla		artment of tificate o		ınd Me		giene Reg. No 2004	20103
	Physici	an	1. Decedent's Name (First, Middle, Last)	T-1-1					. Date of Dea Month	Day Year	3. Time of Death
N.	/Medic	al	DeSales I. Sa. Facility Name (If not institution, give stree	Heisler		4b. City, Town	or Location of		JUNE	14, 2004 4c. County of Dea	
	Examin	ęr	ROUTE 301 at ROUTE 3			SUBLER		Doaur		QUEEN AND	
	Funeral Director	3	5. Social Security Number 6. Sex 198–24–8711		. last birthday) Yrs.	If Under 1 Year Months Day		Min.	Date of Birt (Month, Date ug 1	9. Bin 8,1934 Pitt	thplace (State or Foreign buntry) csburgh, Pa.
	and	}	Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation					10d. Inside City Limits
	ath with the Marylan 23s or 28a-f show	tor	Pa. Allegheny		Pi	ttsburgl	h				Yes 2□No
	th the or 28a	Director	10e. Street and Number			10f. Zip Code	3			10g. Citizen of What Co	ountry?
	ath wi	rai	251 Sprucewood Str			1521				USA	
36	72 hours after death with the Maryland natural, or Items 23s or 28s-f show diest Exactines: out by nuffic d.al.	by Funerai	1 □ Never Married 2 Married	Vas Decedent Ever in U krmed Forces? ☐ Yes 2 XNo I Yes, Give Year or Dates:		Was Decedent of Yes, specify Co		gin? (Specil , Puerto Rie	fy Yes or No- can, etc.)	14. Race - Ame Black, Whit	te, etc.
9-0	natural;		15. Decedent's Education	n	16a. Deced	dent's Usual Occ kind of work dor	cupation	of working		16b. Kind of Business	/Industry
Maryland 21215-0036	- 2 70	Completed	(Specify only highest grade co. Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	usewife	ired)	or working		Own Hom	ne
d 2	il Hygi other	BeC	17. Father's Name (First, Middle, Last)	- <u>-</u>			18. Mother	r's Name (/	First, Middle,	Maiden Sumame)	
ylar	should bo nd Menta marked umatic ev	ToE	Albert Weiss		,					Carlin	
Mar	is 1 and 2 should be filed within of Health and Mental Hygiene. item 27 is marked other than other traumatic event, It e M.		19a. Informant's Name/Relationship (Type, John W. Heisler III			ng Address (Stre I ighacre				ar, City or Town, State, a	Zip Code)
	1 and Healtl tem 27		20a. Method of Disposition		Place of Dispo	sition (Name of		une 19		20c. Location - City or	Town, State
ō			1 ☐ Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	val from State Que	een of		ال (blace)	une 19 2004	9,	Peters Twp.	. Pa.
Baltimore,	permit. Page Department Important: If any injury o		21. Signature of Funeral Service Licensee			Charles	L. Ste	evens	Funer	al Home Ind more Md. 21	
8760,	Physician /Medical Examiner the pontal-fransit	dicai Examiner	23a. Part 1. Enter the disease of complication shock, or heart failure. List only one call instead of the complete the cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d	Due to (or as a conse	quence of):	PIES	rying, such as (cardiac or r	espiratory ar	rest,	Approximate Interval Between Onset and Death
P.O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and oage 2 should be detached for use as the burial-transi	Physician/Me	in the past 12 months?	f yes, outcome of pregr I □Live birth 2 □ Fet I □ Pregnant at time of I □ Unknown	al death 3]Ectopic pregnal] Other (s <i>pecify)</i>				23d. Date of del Month	livery Day Year
	puires that n signed b	þ	Part II. Other significant conditions contrib	uting to death but not re	sulting in the u	nderlying cause	given in Part I.		23e. Did to	obacco use contribute to res 2 No 3 □ Pr	o the cause of death?
Vital Records,		Completed						_		rmed? prior to death?	utopsy findings available completion of cause of
/ita	sician: Th certificate irector, pag	Be	25. Was case referred to medical examiner?	that.			Out		Check only o		
of \	Physic this c	1 To	1 1 Yes 2 □ No Hosp 27. Manner of Death 2	I 🗆 Inpatient 2 L	ER/Outpatien	IL 3 DOA				lence 5 Other (Spe	city) SCENE
on	ding Ph th. After th funeral	tion	1 □ Natural 5 □ Pending 2 Accident investigation	8a. Date of Injury (Month, Day Year)	Injury	V	Vork? □Yes 25 ⊆ 1	Vo.	14 322A	GER OF C	AR
Division	or Attending Physician: after death. Director: After this certifica in by the funeral director, I	Certification:	- Could not be	8e. Place of Injury - At building, etc. (Spec		eet, factory, offic	CO CO		f. Location (S City or Tox	Street and Number or Ru	ural Route Number,
Ö	tal or A rs after al Director	Cert	4 _ Normold	RO AP	y /			RT			19
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edicai	29a. Certifier (Check only one) 1 Certifying Physicia 2X Medical Examiner:								
	To the H within 24 To the Fi	Med	29b. Signature and title of certifier	a and a control			ense number			29d. Date signed (Mont	h, Day, Year)
	F>F0) Ometa			OC	ME			JUNE 14,	2004
	1		30. Name and address of person who comp	1310, MD)]	Print) 11 Penn	Street	t, Bai	ltimor	e, Maryland	1 21201
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) JUN 2 5 2004	32. Registrar's Sign	A A	books	,				

DHMH 17 Rev 1/2001

Registrar

JUN 2 5

2004

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2000 nnie /Medical 4b. City, Town, or Location of Death 4c. County of Death Fecility Name (If not institution, give street and number) Examiner VILL ARK lin If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Min **Funeral** Days Hours 1 M 2 F 215-03-448 10 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County r than "natural", or Iteme 23a or 28a-f ehow tre Medical Ezaminer must be notified at 1 Yes 2 No PARKV Director BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number SA d FORNIA AVE by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. I ☐ Yes 2 No filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Peges 1 and 2 should be filed within. Department of Health and Mental Hygiene. Important: If item 27 ie marked other than "reny injury or other traumatic event, Ita Mad 2008. College (1-4or 5+) Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be amins IMONO 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) TIMORE 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 29-04 PARKILLOON CEMETERY 4 □ Donation 5 □ Other (Specify) 22. Name and Address of F cility BACT MORE MD 21234. 21. Signature of Funeral Service Lightser EVANS FUNERAL CHAPEL, 8800 HARFORD RD Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part . Enter the disease or commissions that chused the shock, or heart failure. List only only cause on each line. Immediate Cause (Final disease or condition resulting in death) mont Tall **Physician** Due to (or as a consequence of /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit To the Hospital or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Year Month Day in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant at time of death 5 Other (specify) be detached o signed by the 9 Unknown م 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ĢUnknown peen 24b. Were autopsy findings available prior to completion of cause of death? 1_ 24a. Was an autopsy performed? page 2: 1 ☐ Yes 2 ☐No 1 ☐ Yes 2 No certificate 26. Place of Death (Check only one) the funeral director. 25. Was case referred to medical examiner? Medical Certification; To Be Hospital: 1 | Inpatient Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. injury at Work? 5 Pending 2 No 1 Tyes investigation within 24 hours after death. To the Funerel Director: A 2 Accident 6 Could not be determined 28I. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗀 Suicide filled in by 4 🗀 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. npletely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D54578 Additional MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALAMOU MD 2123-5601 Leavers cours RAYMUNDO MARTHA

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUN 2

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month **Physician** Mabel Irene Hodge Me /Medical 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street end number) 4c. County of Death Examiner KWERS, de If Under 24 Hrs. 8. Date of Birth (Month, Day, OCT. 9, If Under 1 Year 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Year) 1918 Months Days Hours 1□ M 2□√F 236-38-9774 85 Director Usual Residence of Decedent 10d. Inside City Limits the Marylend 10a. State 10b. County 10c. City, Town or Location from 27 is marked other than "natural", or forms 23a or 28a-f show other traumatic event, the Medical Examinar must be not that at 1 ☐ Yes 2 No Maryland Directo Harford Edgewood 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1801 Nuttal Avenue West 21040 USA Funerai be filad within 72 hours after death 13. Was Decadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian. 11 Maritel Status Black, White, etc. 1 ☐ Never Married 2 Married ☐ Yes 2 XNo f Yes, Give 1 ☐ Yes 2 X No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mantal Hygiens Important: If item 27 is merked other than any injury or other traumatic event, the Ma once. Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Baltimore, Maryland 21 10 Supply Receiver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Gautier Charles (nmn) Gertrude (nmn) Williams 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) David A. Hodge - Son 19 Oakcrest Court, Bel Air, Maryland 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/22/04 Fallston, Maryland Highview Mem. Gardens 22 Name and Address of Fecility McComas Functal Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed ed by the ettending physician and dateched for use as tha bunel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ģ 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed certificate has 1 ☐ Yes 2 00 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient Other: AND Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA this filled in by the funeral 27. Manner of Death Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural 2 Accident 1 Yes 2 🗆 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu after death. 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cai 29a, Certifier ŧ 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

DHMH 16 Rev 6/95

State

Registrar

31. Dete filed (Month, Day, Year)

JUN 2 5 2004

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Stete Registrar Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** EARL HESS 12:15 PM 22 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** of Bel Air Heulth Bei Air Hartord Mariner If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Min Hours 1**X** M 2 □ F Director 216-28-6415 June 19, 1910 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene.
ant: If item 27 is marked other then "naturel", or Items 23a or 28e-f show they or other then the markle ovent, the Margial Examinet must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Harford Monkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21111 3115 Jarrettsville Pike USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2√2 No Specify Be Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 Carpenter Home Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Unknown Ella Louise Hess 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harold B. Hess / Cousin 3115 Jarrettsville Pike, Monkton, MD 21111 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any njury or once. 4 ☐ Donation 5 ☐ Other (Specify) Highview Memorial Grdns 6-25-04 Fallston, Maryland 21. Signature of Funeral Service Lipensee ^{22. Name and Address of Facility}
McComas Funeral Home, P.A.
1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or compressions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician DNEMONIAC usee /Medical Examiner 00 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a sonsequence of). Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed h reeu Due to (or as a consequence of): 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) P.0. detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan certificate has autopsy performed? 2 No 1 ☐ Yes Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 🗌 Yes 2 - HO of this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: 28d. Describe how injury occurred After Division 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 and manner stated To the 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) cause of death (Ham 23a) (Type, and address

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State

Registrar

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31. Date filed (Month, Pay, JUN 2

Year)

2004

MAI

3. Registrar's Signature

		1 - State RegistrarAMEND ITEM	State of Marylan #19a PER INF G	833 Certificate of Death	Reg. N	
Physic		1. Decedent's Name (First, Middle, I	Hamlett		2. Date of Death Month O C C	Day Yeer 0309 A
/Medi Examir		4a. Facility Name (If not institution, g	give street and number)	4b. City, Town, or Location of Dea		GC. County of Death Baltimore City
Funeral Director			O + Mary und ta Sex 7. Age (In yrs. 1□ M 2XXF 60	last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min	. (Month, Day, Yea	9. Birthplace (State or Fore
D		Usual Residence of Decedent 10a. State 10b. County		y, Town or Location	input 1	10d. Inside City Lim
the Mary 28s-f sh	Director	MD 10e. Street and Number	BALT	FIMORE 10f. Zip Code	100 (1 ☒ Yes 2 ☐
23a or	rai Dir	318 N. Carey St.		21223	U.S.	
within 72 hours after death with the Maryland ene. Than "naturer", or tems 23a or 28a-f show the Medical Evantiner must be notified at	by Funerai	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	.S. 13. Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Mexican, Puei 1 ☐ Yes 2 🔀 No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: BLACK
thin 72 ho e. an "natur Medical	Completed	15. Decedent's (Specify only highest (Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired)	orking 16b.	Kind of Business/Industry
be filed with tal Hygiene dother than event, Item	Ве Соп	9th 17. Father's Name (First, Middle, La		CUSTODIAN 18. Mother's Na	me (First, Middle, Maide	PRIVATE on Sumame)
nould be I Mental narked o	To	SAMUEL BAYES	C Oin		LOUISE JONES	
od 2 sho lth and 27 Is ma		WHITTAMS HAMIETT / HU	JSBAND	19b. Mailing Address (Street and Number or R 318 N. Carey St. Balt		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show important: If item 27 is marked other than "natural", or Items 25a or 28a-1 show almortant: If item 27 is motified at any injury or other traumatic event, the Medical Evantmer must be notified at once.		20a. Method of Disposition 1 X Buriai 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	Removal from State FOI	Place of Disposition (Name of semetery, crematory or other place) rest Hill Cemetery 6-30	Date 20c.	Location - City or Town, State
permit. Pag Department Important: any injury o		21. Signature of Funeral Service Lin	censed	22. Name and Address of Facility WI FUNERAL HOME P.A.		
Physician /Medical Examiner	9 19	shock, or heart failure. List on In mediate Cause (Final disease or condition resulting in death)	a. Due to (or as a conseq	ry Artery Disease	L	Approximate Interval Between Onset and Death
be executed sician and burial-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (or as a consequence of the consequence			· ·
the death certificate be executed y the attending physician and iched for use as the burial-transit	icai	that initiated events	с.	uence of): ancy al death 3 □Ectopic pregnancy		23d. Date of delivery Month Day Year
ss that the death certifica gned by the attending ph se detached for use as th	by Physician/Medical	Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ ✓ 6 9 □ Unknown	c. Due to (or as a conseq d. 23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	ancy Ideath 3 Ectopic pregnancy Seath 5 Other (specify)		Month Day Year
requir been s should	by Physician/Medical	Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Mo 9 □ Unknown Part II. Other significant condition:	c. Due to (or as a conseq d. 23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	ancy al death 3 □Ectopic pregnancy leath 5 □ Other (specify)	1 ☐ Yes 24a. Was an autopsy	Month Day Year Duse contribute to the cause of death 2 □ No 3 □ Probably 4 ☑ Onkn 24b. Were autopsy findings avail
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-	5		60 Name and address of person who completed cause of death (I)em (34) (Type, Print)	7. 130 km	DU, MAMIN
	St Regist	ate rar		•	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2004 Judo /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner BALTIMORE 8 tream sie imonium Year If Under 24 Hrs. If Under 1 9. Birthplace (State or Foreign 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) 'Yrs. Number Date of Birth (Month, Oay, Year) **Funeral** Months Days Hours 220-42-952 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Itama 23e or 28a-f show any injury or other traumatic avent, the Medical Evantmet must be invitited at once. 10a State 10b County 1 ☐ Yes 2 KNo Director MD BALTIMORE imonium 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21234. eam by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 IXYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. OO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10 18. Mother's Name (First, Middle, Maiden Şumame) 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21234 mD20b. Place of Disposition (Name of cemetery crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Gremation 3 ☐ Removal from State FUNERAL CHAPEL - 6-24-04 `4 □Donation 5 □Other (Specify) FOREST HIL 22. Name and Address of Facility BALTIMORE, MD 21234. 21. Signature of Funeral Service Licer complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. FUANS FUNERALCHAPEL, 8800 HARFORD RO. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
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Medicel Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical within 2

State

29b. Signature and title of certifig

Kanahma 31. Date filed (Month, Day, Year)
JUN 2 5 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hartord

32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

29c. License number

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29d. Date signed (Month, Day, Year)

Thesday, June 22, 2004@ 6P

Jones, Malma 06-32-04 @ 1800

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201		L,		completed cause of d			Stree	et, I	Baltin	ore, Mary	yland	21201	
	Sta Registr		31. Date filed (Month, Day, Year) JUN 2 5 2004	151	ar's Signatur	Soul	وع						

			1 - For State Registrar	State of N	Maryland /		artment rtificate			and M	ental Hy	giene Reg. No	000	-	20112
	Physici	an	1. Decedent's Name (First, Middle, Las	t)							2. Date of De Month	Da	y Ye	ear	3: Time of Death
	/Medic		Roberta Ann Kutli								June 2		004		10:00 A M
*	Examin	er	4a. Facility Name (If not institution, give		ər)				Location o	of Death			. County of I		
			6701 Old Washings 5. Social Security Number 6. S		Age (In yrs. last	hirthday)	Syke:			24 Hrs.	8. Date of Bir		arrol		ace (State or Foreign
	Funeral Director			□M 21☑F	61	Yrs.	Months	Days	Hours	Min.	(Month, Da Aug 24	y, Year)		Count	th Carolin
-	D		Usual Residence of Decedent												
	arylar show	_	10a. State 10b. County		10c. City, To	own or Lo	cation							10	0d. Inside City Limits 1 ☐ Yes 2X No
	8a-f	ecto	MD Carrol	L	Syke	svil.						10. 0			
	with t	ä	10e. Street and Number	D.1			10f. Zip						izen of Wha		
	death with the Maryland ms 23a or 28a-f show rinust be notified at	Funeral Director	6201 Old Washingto	n Rd. 12. Was Decede	nt Ever in U.S.	13. \		784 ent of Hi	spanic Orio	nin? (Spe	cify Yes or No		ed Sta		
0	r Itan	臣	1 ☐ Never Married 2 ဩ Married	Armed Force 1 ☐ Yes 2 [s?		f Yes, spec	ify Cuba	n, Mexican	, Puerto	Rican, etc.)		Black, \	White, e	etc.
2-003c	ral', o	2	3 Widowed 4 Divorced	If Yes, Give Year or Date	s:		1 □ Yes 2	! ⊠ No	Specify:				Specify:	1	White
Ö	72 h 'natu	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16	Sa. Deced (Give	dent's Usua kind of wor DO NOT us	l Occupa k done d	ition Juring most	t of workii	ng	16b. K	ind of Busin	ess/Ind	ustry
7	within ne.	m Jd	Elementary/Secondary (0-12)	College (1-4d	or 5+)							Do.	1++====		
7	Hygie Hygie ther t		17. Father's Name (First, Middle, Last)	4		Soc	ial Wo	orke		r's Name	(First, Middle		ltimor	ec	ounty
aua	ontal l	Be C	Robert Arthur Phi	.11ips							11e Gra		oumamo,		
<u>-</u>	should mark mati	ပ္	19a. Informant's Name/Relationship (7	ype, Print)	1	9b. Maifir	ng Address	(Street a			l Route Numb		or Town, Sta	te, Zip	Code)
<u>8</u>	nd 2		Joseph Edward Kut	lik (Hus	band)	6201	01d V	Vash:	ingto	n Rd	• Sykes	vil:	le. MD	21	784
ē,	s 1 a of Her itam othe		20a. Method of Disposition		20b. Place	of Dispo	sition (Nam	e of her place	9)	D	ate	20c. Lo	ocation - Cit	y or Tov	vn, State
Ē	Page nent c int: If iry or		1 ☑ Burial 2 ☐ Cremation 3 ☐ • 4 ☐ Donation 5 ☐ Other (Specify		St. P	eter	the	Apos	tle (Cem 6	/28/20	04	Liber	tyto	own, MD
Daitimor	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene is proported; or Itams 23a or 28a-f show Important: If Itam 27 is marked other than "natural", or Itams 23a or 28a-f show Important; or other traumatic avant, the Modical Examinating mast be notified at Once.		21. Signature of Funeral Service Licent	secun		Bu 22	Name and	Addres	s of Facility	nger:	Rdome	i\f	remat	Mby:	21 ¹⁷ 8 ⁴ ·
			23a. Part1. Enter the disease, or company shock, or heart failure. List only	olications that caus	sed the death. D	o not ent	er the mode	of dying	g, such as	cardiac o	r respiratory a	rest,			Approximate Interval Between
	Fhysician		Immediate Cause (Final disease or condition	$_{a}$ m	dostat	ch	LING(A							Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	as a consequenc	e of):	1								1-1
		e e	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a consequenc	e of):						_			
	uted 1 ansit	를	cause. Enter Underlying												
<u>,</u>	exectant and rial-tra	Examin	that initiated events resulting in death) Last	Due to (or	as a consequenc	e of):									
2/00	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	dical		d			<u>. </u>								
ō	certifica nding ph use as t	Ø.	IF FEMALE:												
X D	death co	Physician/M	23b. Was decedent pregnant in the past 12 months?		2 Fetal dea		Ectopic pre						23d. Date of Month		y Day Year
	he de	ysic	1 □ Yes 2 ☑ No 9 □ Unknown	9 Unknown	t at time of death	5∟	Other (spe	city)							
ř	The law requires that the ate has been signed by th bage 2 should be detache		Part II. Other significant conditions c	ontributing to death	n but not resulting	g in the ur	nderlying ca	use give	n in Part I.		23e. Did t	obacco L	use contribu	te to the	cause of death?
as,	w requires that been signed I should be det	d by									1 🗆 '	res 2	□No 3□	Proba	bly 4 Tunknown
ecora	s bee	Completed									24a. Was		24b. Wer	e autop	sy findings available pletion of cause of
ž	The la	mo									autor perfo	rmed?	deat	h? Yes 2	
		Bec	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o		1.		
0	Physician: r this certific ral director,	၉	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpa			t 3 DO		4 🗀 1401	-	ne 5. Aesi			Specify)	
<u> </u>	ding Phy h. After thi funeral o	ertification;	27. Manner of Death 1 ☑Natural 5 ☐ Pending		njury 28b Day Year)	. Time of Injury		Bc. Injury Work	?		8d. Describe I	now injur	y occurred		
UIVISION	death death ctor:	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		Injury - At home,	farm str	M eet factory		res 2□N		8f. Location (Street an	d Number o	r Rural	Route Number.
≥	after Dira	ertil	4 Homicide determined	building,	etc. (Specify)		ooi, raoiory,	OTTIO			City or To				
	spita hours maral maral	aic	29a. Certifier Certifying Ph	ysician: To the be	st of my knowled	lge, death	occurred a	t the tim	e, date and	d place, a	nd due to the	cause(s)	and manne	r as sta	ited.
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	edicai	(Check only one) Medicel Exen	iner: On the basis and manner		and/or inv	vestigation,	ın my op	inion, deat	m occurre	d at the time,	date and	place, and	due to t	the cause(s)
	To t To t	Σ	29b. Signature and attly of certifier	1	160	MIN	29c.	License	number		_	29d. Dat	te signed (M	fonth, D	lay, Year)
ı	1		· OU	will	UUS	1 4)	D0	035	34	8	6	124K	M	
	10	1	30. Name and address of person who	completed cause of				امنح	1.200	lana.	, chi-	Ma	7 211	ベ ٦	
	Sta	to.	31. Date filed (Month, Day, Year)	32. Regi	strar's Signature	XX	5 4 Y	COL	U	ורועב	wtor	11 1)	וואסנו	U /	
	Registi		HIN 2 5 2004	A TONIA	strar's Signature	Span									

			1 - For State Registrar	State of Ma	ryland / Depa	artment of F			ene g. N2 0 0	4 20116
	Dhusisi		Decedent's Name (First, Middle, Last)					2. Date of Death Month		3. Time of Death
	Physici /Medio		Clara Josephine					June	24, 20	004 2:20 A M
	Examin	er	4a. Facility Name (If not institution, give st	,			Location of Death		4c. County of	
	F		1204 Mill Creek F 5. Social Security Number 6. Sex		(In yrs. last birthday)	Fall If Under 1 Year	STON If Under 24 Hrs.	8 Date of Birth	Ha	riord
	Funeral Director			4 000	70 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Jan. 18	, 1934 N	I. Birthplace (State or Foreign Country) Maryland
	nylanc how		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Ba-f s	cto	Maryland Harford			Fallston				1 □ Yes 2 No
	with the	by Funeral Director	10e. Street and Number			10f. Zip Code	01047	10	g. Citizen of Wh.	•
	eath v	erai	1204 Mill Creek Ro	. Was Decedent E	wor in IIS 12.1		21047	acifu Vaa as Na		American Indian,
(0	r Iten	Fun	1 □ Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🕱 N	0		ispanic Origin? (Sp in, Mexican, Puerto	Rican, etc.)		White, etc.
8	rel', o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🎾 No	Specify:		Specify:	White
21215-0036	filed within 72 hours after death with the Maryland Hygiene. yther than "naturel", or lteme 23a or 28a-f show ent, the Medical Eval.it withings be tradified at	Completed	15. Decedent's Educa (Specify only highest grade		(Give	dent's Usual Occup	during most of work	ing 1	6b. Kind of Busin	ness/Industry
12	within ane. than	mp	Elementary/Secondary (0-12)	College (1-4or 5-	-)	DO NOT use retired Ling Mand	•		Hospia	ta P
	filed Hygiv Sther ent, I	ပိ	17. Father's Name (First, Middle, Last)		5.00	Joerny Maria		e (First, Middle, M		
an	should be f and Mental I s marked or sumetic eve	To Be	William Bisch	1066				daline	Del	'L
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel; or Iteme 23a or 28a-f show any injury or other treumetic event, the Medical Exactive must be notified at once.		19a. Informant's Name/Relationship (Type	, Print)	19b. Mailin	g Address (Street	and Number or Rura	al Route Number,	City or Town, Sta	ate, Zip Code)
	and and Tr 27		Mr. Richard Kouba	(husband			zek Road,		•	
Baltimore,	ges 1 t of H If itel or oth		20a. Method of Disposition 1	noval from State	20b. Place of Dispo- cemetery, cren		θ)			ty or Town, State
Ë	rtmen rtent: njury		'4 □ Donation 5 □ Other (Specify)		Parkwood					e, Maryland
Ba	Depar Impo any ir		21. Signature of Funeral Service Licensee	ler		9705 Beld	is of Facility Sci ur Rd.,	Baltimore	2, MD 2	1236
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one	tions that caused to cause on each line	the death. Do not ente	er the mode of dyin			t,	Approximate Interval Between Onset and Death
	Pnysician /Medical	1	Immediate Cause (Final disease or condition resulting in death)	CONGE		TEART	FAILLU	RE		Oliser and Death
n	Examiner			AORT	consequence of):	NOSIS				
		Jer	Sequentially list conditions, it any, team a to immediate cause. Enter Underlying Cause (Disease or injury		surresquence of):	W0212				
g)	cuted nd ransit	Examiner	that initiated events C.	DIABE	TES	MELLIT	US			
760,	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a	consequence of):					
∞	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	dical	d					-		
) x 6	death certifica attending ph	Physician/Med	IF FEMALE: 230	: If yes, outcome o	f pregnancy				224 Date o	4 4-1
Вох	death a atter d for u	lclar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 4 Pregnant at t	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date o Month	Day Year
o.	that the de led by the detached	hys	9 Unknown	9□ Unknown						
	res that signed b	ру Р	Part II. Other significant conditions contr	buting to death but	not resulting in the un	derlying cause give	n in Part I.	23e. Did toba	cco use contribu	te to the cause of death?
ord	w requir been si should I							1 ☐ Yes	2 12 No 3 [☐ Probably 4 ☐ Unknown
Records,	has be	Completed						24a. Was an autopsy	prior	e autopsy findings available to completion of cause of
	ate The							performe		h? Yes 2□ No
Vital	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	spital:		Othe	26. Place of Death			
ō	F F E	Η.	1 Tes 2 140	1 ☐ Inpatien 28a. Date of Injury (Month, Day		28c. Injury Work	4 Nursing Hor	me 5 X Resident 28d. Describe how		Specify)
<u>o</u>	Attending Ph ir death. ector: After th by the funeral	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Injury		? ′es 2 □ No			
Division of	or Attencatter death Director: in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur	y - At home, farm, stre (Specily)	eet, factory, office		28f. Location (Stree City or Town,	et and Number o	r Rural Route Number,
	itel or A								,	
	To the Hospitel of within 24 hours at To the Funerel D completely filled in	edicai	29a. Certifier 1 Certifying Physic 2 Medical Examine	ien: To the best of r: On the basis of e and manner state	examination and/or inv	occurred at the tim estigation, in my op	e, date and place, a inion, death occurre	and due to the caused at the time, date	se(s) and manne and place, and	or as stated. due to the cause(s)
	To To To To To To To To To To To To To T	Σ	29b. Signature and title of certifier			29c. License				fonth, Day, Year)
	9		/000	HD.		1 145			INE 25	2004
	4		30. Name and address of person who com	0 -	ath (Item 23a) (Type, F	Print)	100	S S.	c. T 10.	HM005 M.D.
	Sta	e	21 Date filed (Month Pay Year)	E SUITE 32. Registrar	's Signature		HKYLAND	×1014 24	ED F. MA	HMOOD M.D.
	Registra		JUN 2 5 2004	Beneva	6	band.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. [] 1. Decedent's Name (First, Middle, Last) 2. Date of Death JUNE 22, 2004 Year KURLAND 11:16P M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SINAI HOSPITAL ER-7 BALTIMORE N/A Months Days Hours Min. FEB. 20, 1922 5. Social Security Number 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1 □ M 2 🕅 F 82 Yrs. 219-16-3099 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ¥ Yes 2 □ No N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4005 FORDS LANE 21215 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🌠 No Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) **BOOKKEEPER** SHOE COMPANY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) MAX KURLAND **GERTRUDE** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PHILLIP MIZRACH / NEPHEW 4005 LABYRINTH ROAD - BALTIMORE, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) BNAI ISRAEL CEMETERY 6/24/2004 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute Myocalial inforction seconds disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4☐Pregnant at time of death Day 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? undetermined maliquency - site 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown mellitus 24b. Were autopsy findings available prior to completion of cause of death?

Physician /Medical **Examiner**

physician and the burial-transit

Box 68760.

o.

Records,

Vital

Division

Examiner

Physician/Medical

Be Completed

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Certification:

Medical

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

10a. State

Funeral

Director

7 is marked other than "natural", or Rems 23a or 28a-f show traumatic evant, the Medical Examinar must be notified at

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked other than "

permit. Pages 1 and 2: Department of Health an Important: If itam 27 Is any injury or other traugnos.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Drahetes

5 Pending investigation autopsy performed?

25. Was case referred to medical examiner' 1 Yes 2 No

27. Manner of Death

2 Accident

3 Suicide

(Check only one)

1 Natural

Hospital: 1 ☐ Inpatient 2 💢 ER/Outpatient 3 ☐ DOA

2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1 ☐ Yes 2 ☐ No

28c. Injury at Work? 28b. Time of

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

Bitetimore Mb

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 030377 29d. Date signed (Month, Day, Year)

30. Name and address of person who pleted cause of death (Item 23a) (Type, Print)

Heights Ave

State Registrar

Pobert M. Cooper mus 31. Date filed (Month, Day, Year)

6503 32. Registrar's Signature

JUN 2 5 2004

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within 2 To tha

			State of Maryland / Den	artment of Health and M	•	•
				ertificate of Death		N2004 20116
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physici /Medic		ISRAEL	KLITZNER	JUNE 22	2004 Year 1:30 P M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			CATON MANOR NURSING CENTER	BALTIMOR	E	N/A
١	Funeral		5. Social Security Number 213-12-2837 6. Sex 7. Age (In yrs. last birthday 11 M 2 F 82 Yrs.) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	JAN 22,	9. Birthplace (State or Foreign County ARYLAND
	Director		Usual Residence of Decedent		0711 223	TITLE
	ryland how		10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	Ba-f s	Director	MD N/A BAI	TIMORE		1,□Yes 2□No
	with the	Dire	10e. Street and Number	10f. Zip Code	109	g. Citizen of What Country?
	eath vs 23s	eral	4011 ROSECREST AVE. 11. Marital Status 12. Was Decedent Ever in U.S. 13.	21215	- ' 4.	USA
(0	r Item	Funeral	1 Never Married 2 Married 1 Yes 2 No	Was Decedent of Hispanic Origin? (Spei If Yes, specify Cuban, Mexican, Puerto F	Rican, etc.)	14. Race - American Indian, Black, White, etc.
21215-0036	be filed within 72 hours atter death with the Maryland that Hygiene. Set other than "natural", or Items 23a or 28a-f show event, I're Mudical Examinat must be notified at	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: WHITE
2-0	72 h	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation a kind of work done during most of workin	16	6b. Kind of Business/Industry
121	filed within Hygiene. ether than "	ldm'	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		PROCERY CTORE
	e filed within al Hygiene. I other than ' vent, I're Ma		17. Father's Name (First, Middle, Last)	PROPRIETOR 18. Mother's Name		GROCERY STORE
an	should be nd Mental marked o	To Be	JOSEPH KLITZNER	(* ************************************	UNOBTAINABLE	
Maryland	shou and M s mar	-		LENA ing Address (Street and Number or Rural	Route Number, (
	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evones.		LILLIAN KLITZNER (WIFE) 8911	L REISTERSTOWN RD	#306 _E	ALTO., MD 21208
Baltimore,	Jes 1 of He If iter		20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetary, cree	osition (Name of practice)		Oc. Location - City or Town, State
ij	Pag tment tant: jury d		`4 □ Donation 5 □ Other (Specify) KOVNA (/2004	ROSEDALE, MD
Bai	permit Depar Impor any in					N & BROS., INC.
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en	1900 REISTERSTOWN RO		
H	900-30		shock, or heart failure. List only one cause on each line.		Tospitatory arres	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) a	buctive therease	1 Dres	ne yeen
13	Examiner					
U	D 5	iner	if any, leading to immediate Due to (or as a consequence of):			
M-	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events c. Due to (or as a consequence of):			
760,	icate be executed physician and s the burial-transit	calE	Due to (or as a consequence or).			
687	ficate g phys is the		d			
Вох	leath certificat attending phy I tor use as the	N/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery
m .	death	icia		□Ectopic pregnancy □ Other (specify)		Month Day Year
P.O.	that the de led by the a detached t	Physician/Med	9 Unknown			
ŝ	Se De	ρ	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.		cco use contribute to the cause of death?
Records,	w requir been si should	Completed	Engrance head portune			2 No 3 SPProbably 4 Unknown
Rec	sician: The law certificate has b irector, page 2 s	dm	Dichelis Mellitus		24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?
Vita	in: The	e Co	25. Was case referred to medical		1□ Yes 2⊠	
>	ysicia s cert direct	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatier	26. Place of Death		se 6 □Other (Specify)
Division of	Attending Physician: The r death. ector: Atter this certificate he ector: Atter this certificate he by the funeral director, page		27. Manner of Death 28a. Date of Injury 28b. Time of		8d. Describe how	
Sio	endir sath. or: At he fur	atlc	2 Accident investigation	M 1 ☐ Yes 2 ☐ No		
Š		Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	Bf. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
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	a Hospita 24 hours 5 Funeral etely fillec	edical	29a. Certifier 15g Certifying Physician: To the best of my knowledge, deat (Check only one) 4 Medical Examiner: On the basis of examination and/or in and manner stated.	n occurred at the time, date and place, an vestigation, in my opinion, death occurred	nd due to the caus d at the time, date	se(s) and manner as stated. and place, and due to the cause(s)
	To the Hospital or At within 24 hours after or To the Funeral Directompletely filled in by	Me	29b. Signature and title of gertifier	29c. License number		. Date signed (Month, Day, Year)
)	, ,,,,,		▶ Malought	2-42521	F	me 22, 2004
			30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) 325 Hospitel 3	Drive In	it 208
	φ		30. Name and address of person who completed cause of death (Item 23a) (Type, D.A. O. C. A. O	Sen Bur	rie, ha	21061
	Sta Registr	-	31. Date filed (Month, Day, Year) 32. Registrar's Signature	oals	`	
	- negistr	-11	11 mil 2 5 2004 Person			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for Amend Item #30 per dvr G832 6/22/04 tas RegistreAMEND ITEM #2&3 PER PHY G832 GP751/04/24/25 Death Reg. No 2. Date of Death JUNE 16, 20043. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2004 LueCretta Keffer 3:00p /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Fullerton Baltimore 19 Elinore Avenue If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours 1 ☐ M 2 🕁 F 89 7/15/1914 Pennsylvania Director 208-03-2687 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No MD Baltimore **Fullerton** Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whal Country? U.S.A. 19 Elinore Avenue 21236 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3X Widowed 4 ☐ Divorced "natural". 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other then eny injury or other traument. College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) LueCretta Foster Joseph Sallinger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1642 Bayside Drive Chester, Maryland 21619 James Keffer Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 6/21/04 Baltimore, Maryland Gardens of Faith ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral)Service Licensee 22. Name and Address of Facility Miller-Dippel Funeral Home Inc. 6415 Belair Road Baltimore, Maryland 21206 23a. Part1. Enter the disease c shock, or heart failure. Lis complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final > 100m **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner 100 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury as a consequence of) Examiner The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No detached for 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by within 24 hours after death.

To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be 1 Yes 2 ☑No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy els 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1No Medical Certification; To 1 Yes 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year, 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifies 10027693 cause of death (Item 23a) (Type, Print) 3010 Gibbons Ave. Balto., Md 21214 Michael A. Hyle 32 Registrar's Signature State Registrar

			1 - For State Registrar		e of Ma	aryland / Dep	artmen e <i>rtificat</i>				•	giene Reg. NG [101	20118
	Physici	an	Decedent's Name (First, Mid	dle, Last)							Date of De Month	ath Day	Year	3. Time of Death
	/Medic			EWIS							JUNE	19		10:40 P
4	Examir	er	4a. Facility Name (If not institut	-					Location of	of Death		4c. Cc	ounty of Death	1
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	Funeral Director		5. Social Security Number 218-36-0831	6. Sex 1 ☐ M 2 🔀		e (In yrs. last birthda 90 Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da 08/30/	y, Year)		place (State or Foreign intry)
		ļ	Usual Residence of Decedent								06/30/	1913	Mary	land
	/land		10a. State 10b. Cour	ty		10c. City, Town or	Location							10d. Inside City Limits
	the Marylar 28a-f show	į	MD Carr	o11		Mt. Air	y.							1 ☐ Yes 2 🖾 No
	r 28g	rec	10e. Street and Number				10f. Zip	Code	-			10g. Citizer	of What Cou	intry?
	h wit	a D	713 Midway Ave	•			217	71				Unite	d Stat	0.5
	dea	ner	11. Marital Status	12. Was	Decedent ed Forces?	Ever in U.S. 13			spanic Orig	gin? (Spe	ecify Yes or No Rican, etc.)		Race - Amer Black, White	ican Indian,
98	or It	by Funeral Director	1 Never Married 2 M	arried 1 📋	Yes 2XI	No	1 Yes		Specify:	1, 1 40110	riiodii, oto.,]	ecify: Whi	
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9	filed Hygi ther	ပိ	17. Father's Name (First, Middle	ə, Last)		Tiomer	lakei		18. Mothe	r's Name	(First, Middle,			
an	ental sental ked c	To Be	Charles Edward	Bennett							abeth M		,	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryla if Health and Mental Hyglene. Item 27 is marked other then "natural", or Items 23a or 28a-f show other treumatic event, the Medical Exams net market addition and other treumatic event, the Medical Exams net markets addition and the satisfiers.	-	19a. Informant's Name/Relatio	nship <i>(Type, Print</i>	t)	19b. Ma	ling Address				I Route Numbe			p Code)
	and 2 ealth a n 27 is		Doris Woodfiel	d (Daugh	ter)		Calli				Airy, 2			
ē,	s 1 a f Hea item othe		20a. Method of Disposition			20b. Place of Dis		ne of	- 1		ate		ion - City or T	own, State
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Baltimore,	구두루를		21. Signature of Funeral Service	e Licensee			22. Name an	d Addres	s of Facilit	У			-	
m	Depared Important Importan		- Colle	1 Killion		. Di	rrier	-Que	en Fu	nera	1 Home	& Cre	matory	=
			23a. Part1. Enter the disease, shock, or heart failure. L	or complications t	that caused	the death. Do not e	nter the mod	e of dying	g, such as	cardiac c	y Rd. W	rest,	id, M	pp o m te Interval Between
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	/Medical		resulting in death)	aDu	e to (or as	a consequen of):		,						
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	leath certifica attending ph I for use as ti	/Me	IF FEMALE:	23c. If yes	s, outcome	of pregnancy						224	. Date of deliv	
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rds	quire in sig uld b	pe pe	Counary	artery	_de	reace					1 🗆 1	∕es 2□N	io 3□Pro	bably 4 dunknown
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Vital Records,	The lav	mo										rmed?	prior to co death? 1 Yes	impletion of cause of
ta		BeC	25. Was case referred to media	cal					26. Place	of Death	1 ☐ Yes (Check only o	242 No	1 🗆 185	2 140
>	d is	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	1 Inpatie	ent 2 ER/Outpati	ent 3 DO	A Othe			ne 5 🗆 Resid		Other (Specia	(v)
Jor	ig Ph ter th neral		27. Manner of Death 1 ✓ Natural 5 ☐ Pend	28a. [Date of Injui	ry 28b. Time	of 2	8c. Injury Work	at		28d. Describe h			,
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Division	I or Attendi after death. Director: A I in by the fu	Certification;	3 ☐ Suicide 6 ☐ Coul 4 ☐ Hornicide dete	mined 286. I	Place of Injubul	ury - At home, farm, s	treet, factory	, office		2	28f. Location (S City or Tox	Street and N	umber or Rura	al Route Number,
	ital or saft of the control of the c	Cer												
	To the Mospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical	29a. Certifier 1 Certify (Check only 2 Medicone)	al Examiner: On t	o the best of the basis of manner sta	of my knowledge, dea f examination and/or ated.	ith occurred a nvestigation,	at the tim in my op	e, date and inion, deat	d place, a	and due to the dead at the time, d	ause(s) and date and pla	d manner as s ce, and due to	stated. the cause(s)
	To t To t	Σ	29b. Signature and title of certification	ier M1	0			. License					gned (Month,	
)	/		1 gag	,			MDI	00054	+636			June :	21, 200	04
	'n		30. Name and address of person	n who completed	cause of d	eath (Item 23a) (Type	, Print)	_						
	U		Dr. Syed Haque	700 Mt	. Cla	ire Ave. I	rederi	ick,	MD 2	1701				
	Sta		31. Date filed (Month, Day, Yea	()	32. Registra	ar's Signature	de	-						
	Registr	ar	JUN 2.5	2004	Com	JU A								

			For State Registrer	State o	f Maryland	•	artmen rtificate					iene	04	201	19
Т	Physici	an	1. Decedent's Name (First, Middle	, Last)	-						2. Date of Deat Month		Year	3. Time	of Death
	/Medic	al	Yipu Liu	aire street and my	m hovi	 -	4h Cin.	Tau	Location	of Death	June	21	2004	5:50	O PM ^M
	Examin	er	4a. Facility Name (If not institution Casey House	, give street and mu	nber)		4b. City,		kvill				unty of Death Montgot	merv	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	ast birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Birth (Month, Day,				or Foreign
L	Director		214-33-4657	1□M 2ĬŬF	81	Yrs.	Months	Days	Hours	Min.	Dec. 6,	1922	Cour	hina	or Foreign
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation						1	Od. Inside (City Limits
	Maryl	tor	Maryland Mont	gomery				Gait	hersh	urg					s 2 No
	or 28a	Irec	10e. Street and Number	<u> </u>			10f. Zip				1	0g. Citizen	of What Cour	ntry?	
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	er dez Itams	une	11. Marital Status 1 □ Nøver Married 2 ፡ Marri	Armed Fo		3. 13.	Was Deced f Yes, spec	ent of Hi	spanic Ori n, Mexicar	gin? (Spe n, Puerto	ecify Yes or No- Rican, etc.)		Race - Americ Black, White,		
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2	Aithin ne.	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 Homemaker									,,,g	0	n Home		
і П	filed v Hygie ther t	ပိ	17. Father's Name (First, Middle,	Father's Name (First, Middle, Last) (Unavailable) 18. Mother's Name (First, Middle, Last)										20770 1 1	labla)
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Baltimore,	ges 1 it of H if ital		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 □Removal from	State ce	ace of Dispo metery, cren	natory or of	her place		June	23,		on - City or To		
Ħ	it. Pa irtmen irtant: njury		 4 □ Donation 5 □ Other (S_k 21. Signature of Funeral Service, 			clawn				200		_	r Spri	ng, MI)
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			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that conly one cause on e	aused the death. ach line.	. Do not ent	er the mode	of dying	g, such as	cardiac c	or respiratory arre	est,		Approxima Interval Be Onset and	tw <i>ee</i> n
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	Colon C									year	
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	s death	sicia	in the past 12 months? 1 ☐ Yes 2 💢 No		oirth 2 ☐ Fetal o eant at time of dea own		Ectopic pre Other (spe					!	Month	Day	Year
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Records,		ed by	Patt II. Other significant condition		eaut Dut Hot lesus	ung in the ur	naeriying ca	use give	in in Part I.			accousec s 2 <mark>1</mark> ∏ No	ontribute to th	ably 4	
eco	e law requ has been je 2 shoult	Completed									24a. Was ar	24	b. Were autor	osy findings	available
<u> </u>	The cate h	Com									perform		death?	2 No	04430 01
Vital	25. Was case referred to medical 26. Place of Death 25. Was case referred to medical 26. Place of Death 27.														
ō	Phys	1: To	1 ☐ Yes 2 ☒ No 27. Manner of Death	1 🗆	npatient 2 🗆 E of Injury th, Day Year)	R/Outpatien 28b. Time of	-	A Bc. Injury	" 4 □ Nu at		me 5 ☐ Reside 28d. Describe ho) Hosp	oice
on	nding lith. :: After e funer	atlor	1 X Natural 5 ☐ Pending 2 ☐ Accident investig		th, Day Year)	Injury	М	3c. Injury Work 1 □ Y	? ∕es 2 ∐ l			,,			
Division of	r Atta	ertification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	ned 286. Place	of Injury - At hon	ne, farm, str	eet, factory	office		2	28f. Location (Str City or Town,		mber or Rura	Route Nun	nber,
	ital or irs afte ral Dir	0													
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	29a. Certifier Certifyin (Check only one)	g Physician: To the Examiner: On the b and man	best of my know asis of examinationer stated.	rledge, death on and/or inv	occurred a restigation,	it the tim in my op	e, date and inion, deat	d place, a th occurre	and due to the ca ed at the time, da	use(s) and te and plac	manner as stree, and due to	ated. the cause(:	s)
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			1 KHG	√				D3.	5635			June	22, 20	004	
	l		30. Name and addess of person Joseph Kaplan		e of death (Item :			d.,	Rockv	ille	, MD 20)855			
	Sta	te	31. Date filed (Month, Day, Year)	32. R	egistrar's Signatu			-							
	Registr	ar	JUN 2 5 2	004 3	mere	4	Lon	1							

			1_ For Stata		partment of Health and			
			Ragistrar 1. Decedent's Name (First, Middle, Last)	CE	ertificate of Death	2. Date of Dea	Rag. No.	20120
	Physici		CHARLES	LONG	-	Month	Day Year	2.30 PM
	/Medic Examir		4a. Facility Name (If not institution, give stree		4b. City, Town, or Location of Dec	June	4c. County of Dea	
			403, W. ORDAG	UCE ROAD	alen Bur	nie	Anne A	rundel
	Funeral		5. Social Securify Number 6. Sex 1 № M	7. Age (In yrs. last birthday	Months Days Hours Mi		y, Year) 9. Bir	thplace (State or Foreign buntry) timore, MD
	Director		Usual Residence of Decedent	69 Yrs.		Dec 27	, 1934 Bal	timore, MD
	show		10a. State 10b. County	10c. City, Town or I	ocation			10d. Inside City Limits
	Ba-1 s	cto	MD Anne Arunde	1 Glen Bur	nie			1 ☐ Yes 2 No
	Mith th	Dire	10e. Street and Number		10f. Zip Code		10g. Citizen of What Co	ountry?
	leath	eral	403 West Ordnance Ro		21061 Was Decedent of Hispanic Origin?	Specify Vec or No.	USA 14. Race - Ame	rican Indian
က္	after dea or Items	Funeral Director	1 X Never Married 2 Married 1	med Forces? ☐ Yes 2 🏋 No	If Yes, specify Cuban, Mexican, Pue	erto Rican, etc.)	Black, Whit	
003	72 hours after death with the Maryland neturel', or Items 23a or 28a-1 show Jical Examiret must be notified at	d by		Yes, Give ear or Dates:	1 ☐ Yes 2 🌠 No Specify:		Specify: Wh	ite
15-("netu	Completed	15. Decedent's Education (Specify only highest grade con	npleted) (Giv	edent's Usual Occupation e kind of work done during most of w	orking	16b. Kind of Business/	Industry
12	filed within Hygiene. other then "	dmo	Elementary/Secondary (0-12) C	ollege (1-4or 5+) Dri	DO NOT use retired)	I	Dept of Agi	ng
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ylar		ToE	Cleveland Long		Flora	Bosley		
Maryland 21215-0036	and and ls m		19a. Informant's Name/Relationship (Type, P		ing Address (Street and Number or F			(ip Code)
	s 1 and 2 f Health item 27 l		Patricia Schreiber / 20a. Method of Disposition	Cousin 698	Quail Drive Gle	-	MD 21061	Your State
JOT.			1 1 Burial 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (2004cify)	val from State cemetery, cre	amatory or other place)	e 26,	Glen Burn	
altimore,	그 돈 만 금		21. Sign Aure of Funeral Se vice Licensee		2. Name and Address of Facility	2004		
Ö	permi Depa Impo eny ir once.			MO1220 1	Second Ave S.W.	Glen Bur	n Funeral H cnie, MD 21	ome PA 061
			23a. Part1. Enter the disease or complication shock, or heart failure. List only one ca	ns that caused the death. Do not enuse on each line.	iter the mode of dying, such as cardia	ac or respiratory arr	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	Coronari	1 Antery o	lise a	21	Onset and Death
	/Medical Examiner		Todaming in dodain)	Due to (or as a consequence of):	m. M. D			1
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	cuted nd ransit	Examine	ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Hyper	ensign			Years
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B	death	Physiclan/M	in the past 12 months?	Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)		Month	Day Year
P.O.	that the ed by th detache	Phys	9 L Ofiknown	□Unknown				
	ires tha signed I be det	by	Part II. Other significant conditions contribut	ing to death but not resulting in the u	inderlying cause given in Part I.		pacco use contribute to	
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Records,	o L o	Completed	Chronic runa	1 faulty		24a. Was a autops perform	v prior to c	opsy findings available ompletion of cause of
_	iicien: Th certificate rector, pag	0	25. Was case referred to medical	al Tramplar	26 Place of De		2 No 1 ☐ Yes	2 No
	d is	To B	examiper? 1 ☑Yes 2 ☐ No Hospit	al: 1 Inpatient 2 ER/Outpatie	Othor		ence 6 Other (Spec	ify)
n of	ding Pt J. After th funeral		27. Manner of Death 1 Natural 5 Pending	a. Date of Injury (Month, Day Year) 28b. Time of Injury	of 28c. Injury at Work?	28d. Describe ho	ow injury occurred	,
Division	Attending It death. ector: After by the fune	icatl	2 Accident investigation 3 Suicide 6 Could not be	a Blace of laine. At home form at	M 1 Yes 2 No	006 16 (0)		
ρ	after Direction Direction of the by	Certification;	4 Homicide determined	 Place of Injury - At home, farm, st building, etc. (Specify) 	reet, ractory, onice	City or Town	reet and Number or Rui n, State)	al Houte Number,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying Physician (Check only 2 Medical Examinar: C	: To the best of my knowledge, deat	h occurred at the time, date and plac	e, and due to the ca	ause(s) and manner as	stated.
	To the He within 24 To the Fu completel	Medical	0/10) a	nd manner stated.	vestigation, in my opinion, death occ			
)	Neit To	<	29b. Signature and title of certifier	1.7	29c. License number	i 9	9d. Date signed (Month)	Day, Year)
			30. Name and address of person who complete	ed cause of death (Item 23a) (Type	Print)		0/23	100 /
	O		S. JASSI 1600 L	RAIN HWY Sui	1 11 01	Burnie.	MD 21	061
	Sta		31. Date filed (Month, Day, Year)		als	7		
	Registra	ar	JUN 2 5 2004 /22	and to be	rune .			

State of Maryland / Department of Health and Mental Hygiene, State Registrar AMEND ITEM #5 PER FH G833 7/09/timicalle of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Bertha B. Mitchell 2004 2:00 AM June /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** Baltimore St. Martin's Home Catonsville If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 09/21/1910 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) 6. Sex 5. 249 S 28th 9482 **Funeral** 1 □ M 2 🕶 F 282-19-1964 93 Pennsylvania Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral, or itame 23a or 28a-f show Examinational be notified at 1 ☐ Yes 2 ☑ No Catonsville Maryland Baltimore Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 601 Maiden Choice Lane 21228 United States Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Neyer Married 2 Married Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 No 21215-0036 Specify: White 3 ₩idowed 4 Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry r than Elementary/Secondary (0-12) College (1-4or 5+) Hairdresser Cosmetology 10 18. Mother's Name (First, Middle, Maiden Sumame) Baltimore, Maryland 17. Father's Name (First, Middle, Last) 27 is markad or traumatic ever Mary Kalinauskas John Bruzgas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 205 Sommers Place, Chestertown, MD 21620 Item 27 Mary Coryell / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Importent: If Ite any injury or ott Burial 2 ☐ Cremation 3 ☐ Removal from State 06/26/2004 Baltimore, Maryland Holy Redeemer Cem. * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility David J. Weber Funeral Homes, PA 5311 Edmondson Ave. Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** anc 2 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Dua to for an a consequence of Examiner The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy 1 Live birth 2 Fetel death in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Sclentic Cardio Vascular 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed stension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 DNo 1 ☐ Yes 2 ☐ No certificate or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မှ this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 T Homicide hours after within 24 hours a

To the Funerel I

completely filled tild Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wilkens AT. Baltimor, 4021229 SAMBANDAM 32. Registrar's Signatur 31. Date filed (Month, Day, Year) State JUN 2 5 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene

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	Examine		4a Fecility Name (If not insti	tution, give s	street end num	ber)			4	b. City, Town,	or Location of D	Deeth	4c. County	of Death		
		K	Allegany	County	7 Nursi	ng Home	2				erland			llega		
	Funeral		5. Social Security Number	6. Sex	: IM: 2□ F	7. Age (In yrs. I		If Under Months		If Under 24 H	in. 8. Date o	f Birth , Day, Yo	9a <i>r)</i>	9. Birthp Coun	lace (State of try)	r Foreign
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lar	should be filed vand Mental Hygies a marked other tumatic event, it	0	Granville M	cDona1	.d					Alzin	a Hood		,*			
68760, Baltimore, Maryland 21215-0020	shound N		19a. Informant's Name/Rela	tionship (Ty)	pe, Print)		19b. Mailin	g Address	(Street		Rural Route No		ity or Town,	State, Zip	Code)	
	nd 2 lith a 27 is r tra	- 1	Carol Nesbit	/ daug	hter		133	Orch	ard	Street	Kevse	r W	V 26	726		
	ges 1 art of Hee	1	20a. Method of Disposition	_		20b. PI	lace of Dispo	sition (Nam	e of	(a)	Date		. Location -		wn, State	
	Page ent o of: If I		1 ☑ Burial 2 ☐ Crema 4 ☐ Donation 5 ☐ Oth		emoval from S	itate	sville				June 24	,				
Ħ	Demit. Par Department mportant: any injury once.	Ť	21. Signature of Funeral Ser		p /	riays	the second secon			ss of Facility	2004	-	Maysv		WV	
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		-	23a Part 1 Enter the disease	e or compli	cations that co	used the death	Do not ent				et Key			2672		
	Dhysisian		23a. Pert1. Enter the diseas shock, or heart failure.	List only on	e cause on ea	ich line.		A		g,		.,		1	Approximate Interval Betw Onset and D	veen Death
J.	Physician / /Medical		Immediate Cause (Final		0	0 0-000	1000	1		01	- A	-		1	2(1)	
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m	d for	icia B	Part II. Other significant cor	ditions con	tributing to des	ath but not resu	ulting in the ur	derlying ca	wee aiv	en in Part I	23h	Did toba	CCO LIBE CO	ntribute to	the cause o	of death?
P.0	the cay the arche	hys	A Law 1	one con	1	l.	t .	idenying ca	iuse giv	on an anti.		1100	2□ No		mably 4⊟t	
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of Vital Records,	v requires that the death certificate be been signed by the attending physicial should be detached for use as the bur	Completed by Physician/	A. (A.	Art	-1.21	dund	.01.0	1	8 5		24a. V	Ves an a	utopsy	24b. We	re autopsy fi	indings
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ā	icate	ပ္သို	OF Mean case referred to me	eliant								Yes	2 X No	1	Yes 2	NO
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of	Physical d	<u>۹</u>	1 ☐ Yes 2 No 27. Manner of Deeth				ER/Outpatien 28b. Time of		Bc. Injur Wor		g Home 5 F		njury occur)	
on	ding h. After fune	ig	1 🗷 Natural 5 🗆 Po	ending vestigation	28a. Date of (Month	, Dey Year)	Injury	м		k? Yes 2 ∐ No			, , , , , , , , ,			
Division	Attending in death.	lca	3 ☐ Suicide 6 ☐ C	ould not be	28e. Place o	of Injury - At ho	me, farm, str	et, factory.			28f. Location	on (Stree	t and Numb	er or Rura	i Route Numi	ber,
$\frac{5}{2}$	or after Dire	T e	4 ☐ Homicide	nemmieu	building	g, etc. (Specify)				City or	Town, S	tate)			
	spital ours ours filled	2	29a. Certifier Cor	tifving Phys	iclan: To the b	est of my know	vledge, death	occurred e	et the tin	ne, date and pla	ace, and due to	the ceus	e(s) and ma	inner as st	ated.	
	To the Hospital or Attending Physician: The is within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edicai Certification:				sis of examinati					curred et the ti)
	of the		29b. Signature and title of ce	rtifier	1 .			29c.	Licens	e number		29d.	Date signe	d (Month, L	Day, Year)	
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			1 - For State Registrar	State of M	larylan		artment of F tificate of		d Mental Hy	giene	20123
	Physic /Medi		1. Decedent's Name (First, Middle, Last Elmer Mosley						2. Date of De Month	aath Day Yea 22 2004	3. Time of Death 10:00 A
	Examir		4a. Facility Name (If not institution, give	Falls R	oad		4b. City, Town, o Baltin	nore	Peath	4c. County of De	
	Funeral Director		5. Social Security Number 6. Se 242-54-5106	7. A	ge (In yrs. 66	last birthday) Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of Bir Min. (Month, Da July	9. E 23, 1937	lirthplace (State or Foreign Country) N. Carolina
	Maryland a-1 show	tor	10a. State 10b. County Maryland N/A			y, Town or Lo Baltim					10d. Inside City Limits Yes 2 □ No
	th with the 23a or 28. ust be not	al Director	10e. Street and Number 827 N. Arlingt	on Ave	#40)3	10f. Zip Code	1217		10g. Cilizen of What o	Country?
980	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-1 show its Medical Examinat must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	? KNo	1	Was Decedent of H f Yes, specify Cuba I ☐ Yes 2☐ No	ispanic Origin an, Mexican, P Specify:	? (Specify Yes or No uerto Rican, etc.)	14. Race - An Black, Wt Specify: B	
21215-0036	73 50 10 100	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12th grade	cation e completed) College (1-4or	5+)	(Give	lent's Usual Occup kind of work done o DO NOT use retired	during most of	working	16b. Kind of Busines Eastern Blinds	s/Industry Venitician
Maryland	d 2 should be filed th and Mental Hygi 7 Ia marked othar traumatic event, II	To Be C	17. Father's Name (First, Middle, Last) Woodrow Mosley 19a. Informant's Name/Relationship (Ty	no Print				Essie	Name (First, Middle Mae McC	Соу	
Baltimore, Mary	s 1 and 2 of Health a item 27 Is othar tra			Sister emoval from State	20b. P	4005	Duvall	Avenu	e Baltin		yland21216 or Town, State nston, N.C
Baltir	permit. Page Department of Important: If any injury or once.		21. Signature of Juneral Service Licks			22	. Name and Addres	ss of Facility	Chatman-	-Harris F	uneral Home , Md 21215
	Physician /Medical		23a. Part1 Enter the disease, or compleshock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	cations that cause ne cause on each	d Ihe death line.	h. Do not ente	er the mode of dyin	g, such as car	diac or respiratory a	rrest,	Approximate Interval Between Onset and Death
F	Examiner	dical Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	rub s a consequ	uento officello	De The J	ehne	Disea	ne	
.O. Box 68	ne death certif the attending thed for use as	Physiclan/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	of pregna 2 ∐ Fetal	incy I death 3	Ectopic pregnancy Other (specify)			23d. Date of do	elivery Day Year
Ω.,	es gu	by	Part II. Other significant conditions con	Ĉa .		ulting in the un	derlying cause give	en in Part I.		obacco use contribute	to the cause of death?
l Recor	The law ate has b page 2 s	Completed	Chromi	Renal	m	mfti	ciency		24a. Was autor perfo	prior to death?	autopsy findings available completion of cause of
on of Vital Records,	Attending Physician: Thr death. ector: After this certificate by the funeral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	lospital: 1 Inpati 28a. Date of Inj (Month, Da	ury	ER/Outpatient 28b. Time of Injury	28c. Injury Work	er: 4 Nursin		dence 6 Other (Sp.	ecify)
Division	ital or Attenders after death al Director: ed in by the	Certification;	3 Suicide 6 Could not be determined	28e. Place of In building, e	jury - At ho tc. (Specify	ome, farm, stre	et, factory, office		28f. Location (S City or Tox	Street and Number or F vn, State)	Rural Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	ledical	one)	sician: To the best ner: On the basis of and manner st	of examinat	wledge, death tion and/or inv	estigation, in my op	oinion, death o	ccurred at the time,	cause(s) and manner a date and place, and du	e to the cause(s)
)	C with T	Z	29b. Signature and title of certifier	and		MD	29c. License	3146	4	29d. Date signed (Mon	eltemore
	7		30. Name and address of person who con SHOALIS A. H.	+SHM1		23a) (Type, F	N. Ent	mu S	it Inite	304 R	altimore mp 214
	Sta Registr		JUN 2 5 2004	And San Control			M .				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 7:30 pm MARTIN E. MILLER JUNE 22 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8352 LOCH RAVEN BLVD. TOWSON

If Under 24 Hrs. BALTIMORE If Under 1 Year 8. Date of Birth (Month, Day, Year) 9/3/21 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1X M 2□F Months Yrs. Director 711-07-6116 MARYLAND Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f show The Medical Examiner of the notified at Director 1 ☐ Yes 2 ☑ No BALTIMORE TOWSON MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8352 LOCH RAVEN BLVD. 21286 USA death v Completed by Funeral 12. Was Decedent Ever in U.S. Agned Forces?

V☐ Yes 2 ☐ No WWII If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 2 should be filed within 72 hours after of and Mental Hygiene. Is markad other than "natural", or iter Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes 🛣 No Specify: 3 Widowed 4 □ Divorced WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done d life. DO NOT use retired) during most of working (Specify only highest grade completed) 12th GRADE (0-12) College (1-4or 5+) ARCHITECHTURAL DRAFTSMAN BROWN-WORRAL-JOHNSON 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MARTIN L. MILLER EDNA V. HANNA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 Ian any injury or other traun once. MICHAEL MILLER/SON 11 GUNVIEW FARM COURT PERRY HALL, MD 21128 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) METRO CREMATORY INC. 6/25/04 CATONSVILLE. MD 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 23a, Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final **Physician** Atheroschotic and was when disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed burial-transit the attending physician and Due to (or as a consequence of): Box 68760 lan/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death Physici 5 Other (specify) P.0. 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, CDIMING HIGRAL 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 🔲 Yes 2 No 1 Yes of Vital the Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 TYes 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral er of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No after death. 2 Accident investigation within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as a sales.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D28673 Monxino June 23, 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 5105 WEAL W. LEVEDS WORD WO 1009 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar JUN 2 5 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** Markiewicz 23, Vincent 2004 10:15PM June /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner 8. Dete of Birth (Month, Day, Year) Baltimore Perry Hall 4319 Mispillion Road If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number **Funeral** 1**X** M 2□ F 215-03-0725 Yrs. 85 MD. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 28e-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, If a Medical Examination in nother traumatic event, If a Medical Examination in nother traumatic event. 1X Yes 2 □ No Baltimore Director Md N/A 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code USA 21224 6924 Conley Street Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Specify: White \$ 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 9 years Self-Employed Upholsterer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be Catherine Zawodney George T. Markiewicz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4319 Mispillion Road, Perry Hall, MD. 21236 Jeff Markiewicz son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Rosary Cemetery June 26,2004 Dundalk, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22 Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part1. Enter the disease, or complications that caused the death. So not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Poncreaker Mexastakic **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-translt be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical To the Hospital or Attending Phyaicien: The law requires that the death certifi within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending I completely illied in by the funeral director, page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 1 ☐ Yes 2 ☐ No 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Dther: 4 Nursing Home 5 Residence 6 Other (Specify) Residence 1 Yes 2 10 2 ER/Outpatient 3 DOA ဥ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Matural 5 Pending 1 Tes 2 No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Contifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29c. License number 29d. Date, signed (Month, Dey, Year) 29b. Signature and title of certifier 20 9559 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JABAC, 4940 EASTERN BALT. ery his WATERB 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registra

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ORIGINAL

Patient fucion os CHARLOTTE NEWSOME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrat Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Newsome ott 3:24 PM 2004 Tune /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital d Bultimore Cety Battimore 5. Social Security Number 129-46-788 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex **Funeral** 9. Birthplace (State or Foreign 1 M 200 F Months Days Hours 129-46 New Director OTK Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at 10 ANDI Kaltimore 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2120 or items 23a by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 black 1 ☐ Yes 2 No Specify If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced "naturei", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 'Department of Health and Mental Hygiene. Important: if tiem 27 is marked other than "any injury or other traumatic event, the Mac other. College (1-4or 5+) Sing BING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden DU16 ea Number, City or Town, State, Zip Code) Saltimore, Md 21207 Informant's Name/Relationship 19b. Mailing Address (Street and Nu 52 19 MILL 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 MCremation 3 ☐ Removal from State Dr * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens real Service PA Balt MD 21201-1825 en 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis Weel /Medical Due to (or as a consequence of): **Examiner** mouths Fibrosis Pulius nary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of): the attending physician Box 68760 requires that the death certificate be ian/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Physici 4 Pregnant at time of death 5 Other (specify) P.O. à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 22 No Division of Vital Yes Hospital or Attending Physicien: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: Injury 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 🗀 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medica 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Brodowhoete 140 -000 2004 June seman who inampleted nature of death

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Signature

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BRADAUSKA ITE

31. Date filed (Month, Day, Year,

JUN 2 5 2004

John Nicklow 04-04047 RJ unpend item#23a-b,27,PER ME,G833,7/8/04eg
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend item#1 Ctata of Manuford / Department of Health and Manuford Hugings

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			Registrer 1. Decedent's Name (First, Middle, Las	t)		Timeate of	Death	2. Date of De.		3. Time of Death
П	Physici			ichard	Nicklow,	Tr		Month	Day Ye	
	/Medic Examir		4a. Fecility Name (If not institution, give		NICKIOW,		or Location of De		4c. County of E	
	LXAIIII		North Arundel Hos	spital		Glen	Burnie		Anne Ar	rundel County
	Funeral		5. Social Security Number 6. Se	7. Age	(In yrs. last birthday)		If Under 24 H		th 9.	Birthplace (State or Foreign Country)
ğ	Director		218-84-0337	ZM 2□F 3	Yrs.	Months Days	Hours Wil	Sept.		Maryland
)	pu ,		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	antion .				10d. Inside City Limits
	shov	7	,							1X Yes 2 No
	h the Maryland r 28a-1 show	Director	Maryland Anne Art	ındel	Ode	nton 10f. Zip Code			10g. Citizen of Wha	
	with a or	ā		Danisa			01110			
	death with the Maryland ms 23a or 28a-1 show	eral	1313 Chapelview	Drive 12. Was Decedent Ev	ver in U.S. 13		21113	(Specify Yes or No	United S	Tates American Indian,
	fter d	Funeral	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 😿 No)	If Yes, specify Cub	an, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	Black, V	Vhite, etc.
036	urs a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □ Yes 2X No	Specify:		Specify:	White
2-0	72 hours after death with "natural", or Items 23a or	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Dece	dent's Usual Occup	pation	vorking	16b. Kind of Busine	ess/Industry
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and	be fil ntal H ed otl	Be	17. Father's Name (First, Middle, Last)	37. 1.1	C				Maiden Surname)	
Maryland 21215-0036	es 1 and 2 should be filed within 72 hc of Health and Mental Hygiene. I itam 27 Is marked other than "natur r other traumatic event, Ita Marical	2	John Richard	Nicklov		4 11 (01	Lillia		garet er, City or Town, Sta	Conover
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	1 and Healt am 2	1	Shanna Nicklow/1 20a. Method of Disposition	wile	20b. Place of Dispo	sition (Name of		Date	n, Maryla: 20c. Location - City	
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altimore,	permit. Pages Department of I Important: If its any injury or of		21. Signature of Funeral Service Licen	\sim					Odenton,	
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			23a. Part1. Enter the disease, or comp shock, or heart failure. List only							Approximate
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	/Medical		disease or condition resulting in death)	a Due to (or as a	consequence of):					
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90	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a	consequence of):					
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Ö	t the de by the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown		2 Carior (Speciny) _				
4	that the de	by Physician/M	Part II. Other significant conditions of	ontributing to death but	not resulting in the u	nderlying cause giv	ven in Part I.	23e. Did to	obacco use contribut	te to the cause of death?
Records,	quires n sign Jd be							1 D Y	res 2 10 3	Probably 4 Unknown
00	w requ	lete						24a. Was		autopsy findings available
Re	The law cate has page 2:	Completed							rmed? deat	to completion of cause of h? Pes 2 \sum No
Vital		a	25. Was case referred to medical				26. Place of D	eath (Check only o		765 2 140
Į V	d s	To B	examiner? 1½ Yes 2 □ No	Hospital: 1 Inpatient	t 2 REP/Outpatier	nt 3 DOA Ott	200	Home 5 ☐ Resid		Specify)
η of			27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day)	Year) 28b. Time o	f 28c. Inju	ry at rk?	28d. Describe h	now injury occurred	
Division	Attending r death. actor: Afte	Certification:	2 Accident investigation				Yes 2 No			
Ξ		ij	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	y - At home, farm, st (Specify)	reet, factory, office		28f. Location (S City or Tow	Street and Number of vn, State)	r Rural Route Number,
	e Hospital or 24 hours afte e Funaral Dir etely filled in		00 0.48							
	e Hospital 24 hours a e Funaral etely filled	Medical	29a. Certifier 1 Certifying Phyone Check only one	ysicien: To the best of niner: On the basis of e and manner state	my knowledge, deat examination and/or in	h occurred at the ti- vestigation, in my o	me, date and pla opinion, death oc	ce, and due to the c curred at the time, c	cause(s) and manne date and place, and	r as stated. due to the cause(s)
	To the within 24	Mec	29b. Signature and title of certifier	and manuel state	30.	29c. Licens			29d. Date signed (M	
	F 3 F 8		1	1 /m	(1	oa			June 20,	
			30. Name and address of person who	completed cause of do	ath (Item 23a) (Tuna	Print)				
			MALL C.	1,0016 1	(Type,	1111 Per	nn Stree	et, Baltin	more, Mary	yland 21201
	Sta	ite	31. Date filed (Month, Day, Year)							
	Regist	4.1	JUN 2 5 2	004	's Signature	DB4CL				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Lest) 2. Date of Deeth 07 2004 4c. County of Death 4e Fecility Name (If not institution, give e street end number) arroll 5. Social Security Number If Under 1 Year 6 Sax . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) CANADA Days Months Hours 1 □ MX X □ F 003-09-6919 Yrs. 83 Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits CARROLL SKYESVILLE 1 ☐ Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7200 THIRD **AVENUE** 21780 U. S. A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes X No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Status 1 Never Married XX Married 1 ☐ Yes 2 XXIVO Specify: WHITE Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ASSISTANT BANKING MANAGER YEARS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Lest) **ALBERT** CORLISS NANCY DEMICK 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 7200 THIRD AVENUE, SKYESVILLE, MARYLAND, 21784 CYNTHIA A. BUTANIS (DAUGHTER) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) TIMONIUM, MARYLAND DULANEY VALLEY MEM.GAR. 06-28-2004. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1050 YORK ROAD RUCK TOWSON FUNERAL HOME, INC. TOWSON, MD. 21204 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) lomen fin Due to (or as a consequence of) Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1. 1485 2 MIN. 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Medical Certification: To Be Completed by Physician/Medical

Physician

/Medical

Examiner

10a. State

MD.

Funeral

Director

permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menial Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner mant be notified at

Physician

the Hospital or Attending Physician: The law requires that the death certificate be executed

Director: After this certificated in by the funerel director, peg

death.

within 24 hours a
To the Funeral C

Division of Vital Records, P.O. Box 68760

/Medical Examiner

Baltimore, Maryland 21215-0020

Be Completed by Funeral Director

ပ

	Was case examiner?		d to medical
27.	Menner of		
	1 -Natura	al	5 Pending

28e. Date of Injury (Month, Dey Year) 5 Pending investigation

30. Name end address of person who completed cause of death (Item 23e) (Type, Print)

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

28d. Describe how injury occurred

1 Yes 2 No

234.	CALILIA
	(Check only
	one)

2 Accident

3 ☐ Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as steted.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier fore f. Mon,

C. Mis 72

6 Could not be determined

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

31. Date filed (Month, Day, Year)

32. Registrer's Signeture

114

JUN 2 5 2004

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** Bertie Dee Hale Oden 23 2004 3:45 A June /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Sunrise of Columbia Columbia Howard If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🕱 F Director 163-05-9149 98 May 13, 1906 Tennessee Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural" 10a State 10c. City, Town or Location 10d. Inside City Limits 10b County 1 Yes 2 No Director Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6500 Freetown Road 21044 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🖾 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Completed by White 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Coilege (1-4or 5+) Elementary/Secondary (0-12) 12th Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be John Hale Laura Hale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen Francis Oden/Son 1020 10th Street, Laurel, MD 20707 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ¹ 4 □ Donation 5 □ Other (Specify) West Arundel Crem. 6/24/2004 Odenton, MD 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licensee 438 M00770 313 Talbott Avenue, Laurel, MD 20707 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Pneumonia /Medical Due to (or as a consequence of): **Examiner** Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physiclan/Medlcal use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 XNo Year Month Day 4☐Pregnant at time of death 5 Other (specify) the a 9 Unknown signed by the Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 反 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? page 2 certificate 2 😾 No 1 Yes 2X No To the Hospital or Attending Physician: uneral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Cthen 4 Nursing Home 5 Residence 6 \times Other (Specify) 1,1 Vin 9 Assisted Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2X No Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 X Natural 5 Pending 1 🗌 Yes 2 🗌 No investigation 2 Accident filled in by the I within 24 hours after death To the Funeral Diractor: 6 Could not be determined 3 Suicide 28e. Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier monter D31927 June 23, 2004 n 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ho-Lai Feng, M.D. Two Knoll North Drive, Columbia, MD 21045 31. Date filed (Month, Day, Year) Registrar's Signature State JUN 2 5 2004 Registrar

		1 - For State Registrar	State of Maryland /	Dep		f Health and	Mental Hy			20121
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Physic /Medi		Jules Robert Par	nneton				June	23 2004 2:25 PM		
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Funeral Director		5. Social Security Number 6. Se 577-10-4987A Usual Residence of Decedent	7. Age (In yrs. last)	Yrs.	If Under 1 Ye Months Da			y, Year)	9. Birti Co New	nplace (State or Foreign untry) Hampshire
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2 sho and is me		19a. Informant's Name/Relationship (Ty		9b. Maili	ng Address (Stre	eet and Number or R	ural Route Numb	er, City or	Town, State, Z	ip Code)
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To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, str	0.00		28f. Location (Street and Number or Rural Route Number, City or Town, State)			al Route Number,
To the Hospitel within 24 hours a To the Funerel I completely filled	Medical C	29a. Certifier 1 Certifying Physical Continuous 2 Medical Examination	sician: To the best of my knowled ner: On the basis of examination a and manner stated.	ge, death and/or inv	n occurred at the vestigation, in m	time, date and place y opinion, death occu	e, and due to the curred at the time,	cause(s) a date and p	and manner as a place, and due to	stated. o the cause(s)
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13-X,		30. Name and address of person and co	mpleted cause of death (Item 23a	(Type,	Print)	45947	Carry.	illa.	= ms	4029
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Regist	rar		Realized St.	A ROY						

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** PAKULLA GERHARD IUN 7:00 PM WOLFGANG 23 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOWARD COUNTY COLUMBIA GENERAL NUSPITAL HOWARD If Under 1 Year If Under 24 Hrs. Months Days Hours Min. June 16 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months ^{Year)} 1920 84 Germany June Director 161-12-4577 Usual Residence of Decedent Show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or Items 23a or 28a-f shov It a Medicul Exeminar must be notified at Columbia 1 ☐ Yes 2 X No Director MD Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7080 Craddlerock Way 21045 U.S.A. 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ▼Yes 2 No within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: þ If Yes, Give Year or Dates: Specify: White 3 ♥ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Business Owner 11 Taxi Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 12 should be fi h and Mental H 7 ie marked ot Emil Pakulla Martha Funk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ant: If itam 27 is Gary Pakulla - Son 9063 Dunloggin Rd; Ellicott City, MD 21042 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State injury or permit. Page Department of Important: If any injury or Bayview Crematory * 4 ☐ Donation 5 ☐ Other (Specify) 6/25/2004 Baltimore, Maryland 22. Name and Address of Facility Wise Funeral Services, P.A. 700 S. Beechfield Avenue; Baltimore, MD 21229 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Part1. Enter the disease, shock, or heart failure. 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DHMH 17 Rev 1/2001

ORIGINAL

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			Decedent's Name (First, Middle, Last))		2. Date of Death Month		3. Time of Death
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	4		30. Name and address of person who comp	leted cause of death (I	tem 23a) (Type,	law 51	Bull	imore	MD 21	20/
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Si		1				

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last)

Jewell E. Pierelli **Physician** June 2004 2.00 A /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** HOSPILONI Rosedo-Square mot lanklin 9. Birthplace (State or Foreign Country) W.VA. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days 1 □ M **XX**F 220 18 3588 Director Usual Residence of Decedent 10c. City, Town or Location Dundalk 10a. State MD . County Baltimore 10d. Inside City Limits or items 23a or 28a-f show or other traumatic event, the Madical Examiner must be notified at 1 ☐ Yes XX No Funeral Director 10f. Zip Code 21222 10g. Citizen of What Country? 7308 Alvah Avenue **USA** filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any jury or other traumatic event 2008. Everett Williams Alma Parsons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank A. Pierelli HUSBAND 7308 Alvah Avenue Dundalk Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XXBurial 2 ☐ Cremation 3 ☐ Removal from State 6/26/04 Oaklawn Cemetery Baltimore, MD. ⁴ □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Cvach/Rosedale Funeral Home 21. Signature of Funeral Service Licensee 1211 Chesaco Avenue Rosedale Maryland 21237 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final FO-Physician ena disease or condition resulting in death) month /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in its lead enter in the cause of t Due to (or as a consequence of) Examiner the burial-transit or Attending Physician: The law requires that the death certificate be execute that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Certification: To Be Completed by Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregrant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy signed by the atte Month 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ 9 ☐ Unknown Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cate has I 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Physician D0054303 1) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

Dr. Zoyd Eladah 9000 Flanklin 32. Registrar's Signature

Square

Drive Baltimore, MD

Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Code 11d. Marital Status 12 Was Decedent Ever in U.S. Armed Forces? 11 Never Married 11 Never Married 11 Never Married 11 Never Married 11 Never Married 11 Never Married 11 Never Married 11 Never Married 11 Never Married 11 Never Married 11 Never Married 11 Never Married 11 Never Married 11 Never Married 11 Never Married 11 Never Married 11 Never Married 11 Never Married 11 Never Married 12 Never Married 13 New Specific 14 Never Married 15 Never Married 16 Never Married 17 Never Married 18 Never Married 19 Never Married 19 Never Married 19 Never Married 10 Never Marr	ath irthplace (State or Foreign Country) akistan 10d. Inside City Limits 1 Yes 2 No Country? stan nerican Indian, lite, etc. sindustry Dyed Zip Code)
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The state of the s	Zip Code)
Ashfaq Hussain 19a. Informant's Name/Relationship (Type, Print) Syed A. Quadeer-Husband 2ainab Bibi 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 5919 Charwood Road, Catonsville,	
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Syed A. Quadeer-Husband 5919 Charwood Road, Catonsville,	Md 21228
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	
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20. Mentod of Disposition 1 Manual 2 Cremation 3 Removal from State 1 Manual 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) King Memorial Park 6/24/04 Randallst 4 300 Wabash Ave, Baltimore Md	21215
23a. Pent. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between
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/Medical resulting in death) Due to (or as a consequence of):	
Examiner Sequentially list conditions, b. BILATEAN DIRLIGHANT PLEURAL EFFUSION	
Cequentially list curultions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	
That influence events C.	
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So Contribute Specific Specifi	Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute 1 Yes 2 No 3 F 24a. Was an autopsy performed? 1 Yes 78 No 1 1 Yes 78 No 1 1 Yes 1	to the cause of death?
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L S 25 C Interest Specification Control of the sidence of Control of Control of the sidence of Control of Cont	ecify)
28a. Date of Injury 28b. Time of Injury at Work? 28d. Describe how injury occurred Work?	
O TO TO TO TO TO TO TO TO TO TO TO TO TO	Zurad Planta Murahan
25. Was case referred to medical examiner? 1	urai noute ivumber,
25. Was case referred to medical examiner? 1	s stated. e to the cause(s)
29d. Date signed (Mor	
axu eximon P Mehla m.o Doc 41410 June 23	2004,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHINGEL P MEHTH	+
MORTHWEST STOSPITAL CENTER RANDAUSTOWN MD 21133.	
State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature	

منتنور		1 - State Amend Item 9 Registrar 1. Decedent's Name (First, Middle, Last)		Ochinc	ate of De	- aur	2. Date of Death	. No.5 U U	3. Time of Death
Physici	an	Ernest			Robins	con	Month June	Day Ye 12 20	ar 12 50 00
/Medio		4a. Facility Name (It not institution, give	street and number)	4b. C	ity, Town, or Lo		-	4c. County of D	
. A		THE HOPEN HOPE	ins HOSPITAL	1	Altin	out			
Funeral Director	4	5. Social Security Number 6. Security Number 15482 Usuel Residence of Decedent	M 2□F	3 Yrs.		Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	ear)	Birthplece (State or Foreign Country) MD VIRGINI
Mot		10a. State 10b. County		, Town or Location					10d. Inside City Limits
a-ta Bigg	ctor	maryland	<u> </u>	Baltim	ore				1 Yes 2 No
23a or 21 st be no	Funeral Director	201 N. Washi	naton	1	Zip Code 2123	1	10g	Citizen of What	
artment of Health and Mental Hygiene. ortant: If Item 27 is marked other than "natural", or Items 23s or 28s-f ahow injury or other traumatic avant, the Medical Examiner must be notified at	by Funer		12. Wes Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 (1) No If Yes, Give Year or Dates:		cedent of Hispa pecify Cuban, N		pecify Yes or No- o Rican, etc.)	Black, V	American Indian, White, etc. Black
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Departr Imports any inju	2 4	1 and July	Inter	7639	N. P	Road	ay Ba	Ho. md	21213
nysician Medical		23a. Part1. Enter the disease, o complete hock, or head tailure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. e cause on each line. SCP STS Due to (or as a consequ		node of dying, s	uch as cardiac	or resoratory arrest		Approximate Interval Between Onset and Death U Days
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physician and s the burial-transit	Ical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	ence of):					
the attending hed for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3 □Ectopic	pregnancy (specify)			23d. Date of Month	delivery Day Year
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has ye 2	Completed						24a. Was an autopsy performed	prior death	
r death. ector: After this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner?				. Place of Dea	th (Check only one)		
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within 24 hours after To the Funeral Dis completely filled in	edical (29a. Certifier 1 ☑ Certifying Phys (Check only one) 2 ☐ Medical Examin	sician: To the best of my knowner: On the basis of examinational and manner stated.	vledge, death occurr on and/or investigat	ed at the time, of ion, in my opinio	date and place, on, death occur	and due to the caus rred at the time, date	e(s) and manner and place, and c	as stated. due to the cause(s)
within To the	Me	29b. Signature and title of certifier	11		29c. License nu			Date signed (Mo	* '
		V24.11	1-110		RES-	000	0	une 12	2,2004
1		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type, Print)		(n .	166 41	1 0 11	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 6:13 AM DWARD ENRY 2004 INE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner DAMARITAN TIMORE If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) MARCH 31, 192 7. Age (In yrs 5. Social Security Number 6. Sex Jast birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Months MUTTERY 1**⊠**M 2□ F 219.03.353 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 Is marked other than "natural", or Items 23a or 28a-f shov traumatic avant. The Medical Examinar must be multiful at BALTIMORE 1 ☐ Yes 2 No Director PARKVILLE MARYLAND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if itam 27 is marked othar than "natural", or fler any niury or other traumetic event, the Medical Evaruina. Bong. 1 Yes 2 2 □ No 1 Never Married 20 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: WHITE þ 3 Widowed 4 Divorced Year or Dates: 1942-1945 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) THOGRAPHER MRTON (17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ROGERS HELMA DWARD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WIFE ROGES EILEEN D. PARKVILLE, MD APT PRIDGE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ■Burial 2 □ Cremation 3 □ Removal from State CRELANDMEM. PARK 6/25/04 PARKVILLE, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility EVANS CHAPEL OF MEMORIES HARFORD RD, PARKVILLE, MD 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final dano Physician / SMINDOW 10 mp disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner OYSAMG1FO Sequentially list conditions, if any, leading to immediate cause. Erner underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner PNommers be executed burial-transit SOPSUS STAVELLING CS and Due to (or as a consequence of) attending physician Box 68760, Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months?
1 Yes 2 No Year Month Day 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ eq TUSCE Cossus runy 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy penformed? 1 ☐ Yes 2 🗶 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate has To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ★ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending Injury within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of ca

State Registrar

31. Date filed (Month, Day, JUN 2 5 Year) 2004

9712

32. Registrar's Signature

Junalmo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) secon dosso

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			1 - For State of Maryland / Dep	artment of Health and M	lental Hygiene	2 4 1	
	Physici /Medic		Decedent's Name (First, Middle, Last) LILLIAN	ROSENFELD	2. Date of Death Month 22 Day	2004 ^{Year} 6:52 Р м	
	Examin		4a. Facility Name (If not institution, give street and number) MILFORD MANOR NURSING HOME	4b. City, Town, or Location of Death BALTIMORE		County of Death	
	Funeral Director		5. Social Security Number 215-03-2331 6. Sex 1 \square M 2 $\overleftarrow{\mathbb{A}}$ F 7. Age (In yrs. last birthday 98 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth JULY 29, 19	9. Birthplace (State or Foreign Country) NY	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or Items 23a or 28a-1 show eny injury or other traumatic event, the Medical Evaninal Institute Indifferent aggress.	To Be Completed by Funeral Director	10e. Street and Number 130 SLADE AVENUE 11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) ARM Decedent Seducation (Giver Individual Secondary (0-12) 17. Father's Name (First, Middle, Last) ABRAHAM SCHR 19a. Informant's Name/Relationship (Type, Print) 19b. Mail	SVILLE 10f. Zip Code 21208 Was Decedent of Hispanic Origin? (Spulf Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify: dedent's Usual Occupation a kind of work done during most of work DO NOT use retired) MAKER 18. Mother's Name ROSE ing Address (Street and Number or Rura	ocity Yes or No-Rican, etc.) 16b. Ki OWN o (First, Middle, Maiden al Route Number, City o	SILVERMAN r Town, State, Zip Code)		
Baltimore, M	permit. Pages 1 and 2 Department of Health Importent: If item 27 i eny injury or other tra <u>once</u> .		20a. Method of Disposition 1 A Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signatur of Ineral Service Lipples	ZION CEMETERY 6/24 Name and Address of Facility SOL SOLO REISTERSTOWN F	Pate 20c. Lo 1/2004 I 20c. Lo 1/2004 I 20c. Lo 20c. Lo 20c. Lo 20c. Lo 20c. Lo 20c. Lo 20c. Lo	ROSEDALE, MD BROS., INC. SVILLE, MD 21208	
. Box 68760,	The law requires that the death certificate be executed It is been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical Examiner	shock, or heart failure. List only one cause/or each line. Immediate Cause (final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Pause Disease or spirity that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year		
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Division (or Attending fler death. Diractor: After in by the funer	Certification;	27. Mann- f Death 1	Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how injury 28f. Location (Street and City or Town, State,	d Number or Rural Route Number.	
	To the Hospital or Attending i within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical Co	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or is and manner stated. 29b. Signature and title of certifier N : 5 Rayporkse, M.D. Make republic	nvestigation, in my opinion, death occurr	ed at the time, date and 29d. Dat	and manner as stated. place, and due to the cause(s) e signed (Month, Day, Year)	
	¥		30. Name and address of person who completed cause of death (Item 23a) (Type				
	Sta Registi			bals			

1. Decedents Name Prick Middle 1. December of Institute, give states and number) 2. December of Institute, give states and number) 4. December of Institute, give states and number) 4. December of Institute, give states and number) 4. December of Institute, give states and number) 4. December of Institute, give states and number) 4. December of Institute, give states and number) 4. December of Institute, give states and number) 4. December of Institute, give states and number) 4. December of Institute, give states and number) 4. December of Institute, give states and number 4. December of Institute 4. December of Institute, give states and number 4. December of Institute, give state				State of Maryland / Depart 1- State of Maryland / Depart 1- Registrar AMEND ITEM #@&3 PER PHY G833-7-16	ment of H	lealth and M		ene	2011.0
ELIZABETH CATEFURINE RUSSELL Tenders you believe the control of t		Dhysisis	20	, tagotto			2. Date of Death	UN 22,200	
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Due to (or as a consequence of): Sequentially list conditions, at any, leading to immediate classes or injury that imitated events is resulting in death) Last Sequentially list conditions, at any, leading to immediate classes of injury that imitated events is resulting in death) Last Due to (or as a consequence of):	i			Immediate Cause (Final disease or condition					
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25. Was case referred to medical examiner? 1	Š,	e be ex	cai E	d					
25. Was case referred to medical examiner? 1	9	ntificating phy	b9	IF FEMALE:					
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The policy of th	II a		ø	evaminer?	104				
State	ō	Phye this ral di	-	27. Mapper of leath 28a. Date of Injury 28b. Time of	28c. Injury	v at Nursing Hon			ecify)
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and time of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filled (Month, Day, Year) 32. Registrar's Signature	lol:	ath. ath. r: Afte	atior	Accident investigation					
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Daul. 1 2.		To the within To the comple	Me	COL Singer and May of portifier	29c. License	e number	290	d. Date signed (Mon	h, Day, Year)
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State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature		10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print Day). 1 7. //www.d 82/	nt) N. £	V/4 w 4	405 B	& hindre	~ ~
				31. Date filed (Month, Day, Year) 32. Registrar's Signature	rocks				

			1 - For State Registrar	State of Maryland / Dep	partment of Health and Nertificate of Death	•	ne	11.1
	Physici	an	1. Decedent's Name (First, Middle, Last) CHARLES JOHN	STORCK, SR.		2. Date of Death Month	Day Year 3. Tim	ne of Death
	/Media	cal	CHARLES JOHN 4a. Facility Name (If not institution, give s.		4b. City, Town, or Location of Death		20 04 3: 4c. County of Death	19 PM
	Examir	ıer	VETERANS ADMINIST		BALTIMORE		40. County of Boatt	
	Funeral Director		5. Social Security Number 6. Sex	M 2□F 7. Age (In yrs. last birthda) Yrs.	// If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthplace (Sta Country)	ite or Foreign
	yland how		10a. State 10b. County	10c. City, Town or I	Location	··	10d. Inside	le City Limits
	8a-fs	ctor		ORZ PARK	ville		1 🗆 1	Yes 271No
	eath with the 1s 23a or 2	Funeral Director	10e. Street and Number 8429 520 Here 11. Marital Status		10f. Zip Code A1234 Was Decedent of Hispanic Origin? (So		Citizen of What Country?	
980	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show ha Medical Exacting renal be rediffed at	þ	1 Never Married 2 Married Widowed 4 Divorced	Armed Forces? 1-1 Yes 2 □ No If Yes, Give Year or Dates: W	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	Rican, etc.)	Black, White, etc.	,
21215-0036		Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	Completed) (Giv life.	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	ing	Kind of Business/Industry	
d 2	e filed within It Hygiene. other than		17. Father's Name (First, Middle, Last)	FO	18. Mother's Name	e (First, Middle, Maio		WEEN
/lan	should be and Mental is marked of aumatic even	To Be	somuno m.	STORCK	ROSE	n. He	0)	
, Maryland	s 1 and 2 hit Health item 27 l	-	19a. Informant's Name/Relationship (Typ	5RCK 3313	ling Address (Street and Number or Run	JAW 7	JORF, MARYL	Ano
ore			20a. Method of Disposition 1 ☐ Burial ☐ Cremation 3 ☐ Re	20b. Place of Disposer cometery, cr	position (Name of ematory or other place)	Date 23 20c.	Location - City or Town, State	
Baltimore,	permit. Page Department of Important: If any injury or once.		21. 3gn Hrr Funeral 3-rvice License	- 125TH	22. Name and Address of Facility of	600 P	18 K2 175 (JAS.	7/800 3/37 84/6/10
	Pnysician /Medical		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	SEPSIS	nter the mode of dying, such as cardiac	or respiratory arrest,	Approxir Interval I Onset ar	mate Between nd Death
	Examiner	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Criscase or in july	Due to (or as a consequence of): Due to (or as a consequence of):				
,092	te be executed ysician and ne burial-transit	cai Examiner	that initiated events resulting in death) Last	Due to (or as a consequence of):				
P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day	Year
Ś	w requires that been signed b should be deta	by	Part II. Other significant conditions cont Congestive Heart Acute Renal Fo		underlying cause given in Part I.		o use contribute to the cause of	
Record	The law re cate has besc page 2 sho	Completed	Acute Renal F	ailure.		24a. Was an autopsy performed	24b. Were autopsy finding prior to completion of death? 1 Yes 2 No	gs available of cause of
Vital	Phyaician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:	04	(Check only one)		
4	sir dii	ition: To	1 Yes 2 No Ho 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Spital: 1 (☑Inpatient 2 ☐ ER/Outpatie 28a. Date of Injury (Month, Day Year) 28b. Time Injury		me 5 Residence 28d. Describe how in	6 Other (Specify)	
Division	tal or Atter s after dea al Diractor ed in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury · At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Ni te)	umber,
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Diractor: After the completely filled in by the funeral	edicai	(Check only 2 Medical Examin-	cian: To the best of my knowledge, dea er: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurr	ed at the time, date a	nd place, and due to the cause	
	To To	Σ	29b. Signature and title of certifier	e e	29c. License number	29d. [Date signed (Month, Day, Year,)
•	1/1		30. Name and address of person who con	M.D.	Print Department of	In to the	DO NOCHY MA	
6	75,			ANAKIS, M.D.	P17671 Print) Department of University of M	aryland,	Baltimore MD	21201
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature	1	V		

DHMH 17 Rev 1/2001

ORIGINAL

508 Glen Byrnie, md

Physician /Medical Examiner or Attending Physician: The law requires that the ceath certificate be executed

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

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10a. State

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at annea.

Baltimore, Maryland 21215-0020

Examiner as the burial-transit physician Physiclan/Medical signed by the a Completed by hes certificate Be Medical Certification: To this Director: After the within 24 hours e To the Funeral D completely filled i

Division of Vital Records, P.O. Box 68760.

sites, or near tallure. List only o	ne cause on each line.				Onset and Dea	
Immediate Cause (Fina! disease or condition resulting in death)	Deneus	-òc			4000	
resoning in death)	Due to (or as a consequence of	of):			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (of as a consequence of	л).			
Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence o	rf):			
Part II. Other significent conditions con	ntributing to death but not re	sulting in the underlying	g cause given in Pert I.		ontribute to the cause of d	
Hyperterin				1 ☐ Yes 2 ☐ No	3 ☐ Probably 4 ☐ Unit	
Hyperterine				24a. Was an autopsy performed?	24b. Were autopsy find available prior to completion of caus of death?	
Hypulopidence	a a			1 Ves 20 No	1 ☐ Yes 2 ☐ No	
25. Was case referred to medical examiner?	og talest i la			eath (Check only one)		
		ER/Outpatient 3□	OA Other: 4 Nursing Home 5 Residence 6 Other (Specify)			
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occur	red	
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, street, fact fy)	28f. Location (Street and Numb City or Town, State)	 Location (Street and Number or Rural Route Number, City or Town, State) 		
29a. Certifier (Check only one) 1 ☐ Certifying Physical Exemi	sician: To the best of my knoner: On the basis of examination and manner stated.	owledge, death occurre ation and/or investigation	ed at the time, date and place on, in my opinion, death occ	ce, and due to the cause(s) and ma curred at the time, date and place,	anner es steted. and due to the cause(s)	
29b. Signature and title of certifier		2	29c. License number	29d. Date signe	ed (Month, Day, Yeer)	
A huare the	Courses		D19667	06-2	4-2004.	

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1. Schwartz 31. Date filed (Month, Day, Year)

JUN 2 5 2004

7310 Rikhie

2. Registrer's Signature

Sports

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State State Registraramend item #5 PER F8 G834 8/ Gertificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Robert Joseph Schloer 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FRANKLIN SZYARE HOSPITAL RosedAle If Under 1 Year | If Under 24 Hrs. 3A/11 MORE 8. Date of Birth (Month, Day, Year)
NOV. 25,] 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1**X** M 2□ F Min. Hours 212-26-6612-Director 73 1930 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits I7 is marked other than "natural", or Itams 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director Maryland Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1413 Creswell Road 21001 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Xes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: ģ Specify 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Carpenter & Crane Mechanic Steel Manufacturer 8 permit. Pages 1 and 2 should be filled. Department of Health and Mental Horst Important: If item 27 is mediany injury or other: 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 John Henry Schloer Helen (unk) Vandeiver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorna M. Schloer / Wife 1413 Creswell Rd., Aberdeen, MD 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Gardens of Faith Cem. 6-26-04 * 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Juneral Service Acensee McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 Mules a musk 23a. Part1. Enter the disease, or completatives that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one use on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Prey MoniA **Physician** a ASDIRATION disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner EMENTIA Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of); attending physician for use as the burial Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? performed? 2 No 1 ☐ Yes 2 ☐ No Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 2 Accident 5 Pending М 1 Yes 2 No investigation after death Diractor: / 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 Homicide within 24 hours a To the Funeral C Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cer D0056296 6-22-2004 S 30. Name an address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

DR. JASGN DIR 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

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9000

32. Registrar's Signature

NBAUM

JUN 2 5 2004

FRANKLIN SQUARE DR. BAITIMORE Md. 21236

			For State Registrar		Maryland / De		Health and M	-	giene	04 2014	L,
		ш	1. Decedent's Name (First, Middle,	Last)				2. Date of D Month	eath Day	3. Time of Dea	ath
	Physici /Medic		Edward Tall	ev				June		004 11: 10 F	2 M
	Examin		4a. Facility Name (If not institution,	-			or Location of Death		4c. County		
	,		Narthwest Itos				allstown			timore	
	Funeral		5. Social Security Number	5. Sex 7.	Age (In yrs. last birthd	Months Davs		8. Date of Bi	rth ay, Year)	Birthplace (State or Fo. Country)	reign
	Director		212-22-6391 Usual Residence of Decedent		78 Yrs			11/07	/1925	Virginia	
	land		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Li	imits
	Mary f sh	ğ	MD N/A		Balti	more				1 ∑ Yes 2□]No
	1 the	rec	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Country?	
	3e ol	<u></u>	6801 Richards	on Road		2120	17		USA		
	ms 2	Funeral Director	11. Marital Status	12. Was Deced	ent Ever in U.S. 1	Was Decedent of If Yes, specify Cub		ecify Yes or N		ce - American Indian,	
0	or Ite		1 Never Married 2 Marrie		□ No	1 Yes 2 No		nican, etc.)		ck, White, etc.	
3	urel',	d by	3 ☐ Widowed 4 ☑ Divorced	Year or Date	es:	10.00 20.00	opcony.			Black	
5	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "naturel", or items 23e or 28e-f show event, it a Madreal Examinating and event, it a Madreal Examinating and a second seco	Completed	15. Decedent's (Specify only highest	s Education grade completed)	16a. De	cedent's Usual Occup ive kind of work done s. DO NOT use retire	pation during most of work	king	16b. Kind of B	usiness/Industry	
7	should be filed within of Mental Hygiene. marked other than imetic event, it s M	E C	Elementary/Secondary (0-12) 8 years	College (1-4	or 5+)				Airbo	rne Inc.	
2	Hygie ther ther	ပိ	17. Father's Name (First, Middle, L	ast)	111	eght Han	18. Mother's Nam	e (First, Middle			
	d be antal	0	Louis Mint	on			Mary	Talle	V	•	
<u></u>	2 should and Mer is marke eumetic	은	19a. Informant's Name/Relationshi	ip (Type, Print)	19b. M	ailing Address (Street	t and Number or Rui	ra I Route Numi	per, City or Town,	State, Zip Code)	
	nd 2 ulth a 27 is		Jinel William	s/Daught	er 171	9 E. Bal	timore {	St.Bal	toMd	21231	
ก	of Health of Health fitem 27 r other tr		20a. Method of Disposition		20b. Place of Di	sposition (Name of crematory or other pla		Date		- City or Town, State	
2	Pages nenl of nnt: If it ury or o		1 ☐ Burial 2 🔀 Cremation : 4 ☐ Donation 5 ☐ Other (Sp.		ate	Cremator	· 1	26/04	Baltin	more,Md	
Daltillor	permil. Pages Department of Importent: If it any injury or once.		21. Signature of Funeral/Service L	icensee		22. Name and Addre	-	owell	Funeral		
٥	8 9 5 8		- Wille	- HOW E	120	4600 Lib	erty Hei	ights	Ave. Ba	alto.,MD212	207
			23a. Part1. Enter the disease, or of shock, or heart failure. List of	complications that cau	used the de th. Do not ch line.	enter the mode of dyi	ng, such as cardiac	or respiratory	arrest,	Approximate Interval Between	n
	Physician		Immediate Cause (Final disease or condition	Me	etastatic 1	Mr conce	-			Onset and Death	h
	/Medical		resulting in death)		as a consequence of):	7	-				
	Examiner		Sequentially list conditions,	b							
	pe sit	lue	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (clisease or milury that initiated events	Due to (or	as a consequence of):						
	be executed icien and burial-transit	хаш	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								
Ŏ,	be ey icien buria	calE									
	physis the	edic		d							
X	The law requires that the death certificate be executed ate has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Z/Mg	IF FEMALE: 23b. Was decedent pregnant		ome of pregnancy				23d. Da	te of delivery	
ă	death a atter	ciar	in the past 12 months?	4□Pregnar	nt at time of death	3 □Ectopic pregnanc 5 □ Other <i>(specify)</i> _	у			onth Day Year	
į.	the car	hysician/M	9 Unknown	9□ Unknow	m						
Ţ	ned t	by P	Part II. Other significant condition	s contributing to dea	th but not resulting in th	e underlying cause gr	ven in Part I.	23e. Did	tobacco use cont	tribute to the cause of death	1?
cords,	quire an sig uld b							1 🗆	Yes 2 ☐ No	3 Probably 4 Dunkn	own
ာ သ	aw re	ompleted						24a. Was		Were autopsy findings avail prior to completion of cause	able
Ĕ	The I							perf	ormed?	death?	, OI
		Be C	25. Was case referred to medical examiner?		······		26. Place of Deat				
_	Physicien: this certific ral director,	10	1 ☐ Yes 2 No	Hospital: 1 Xing		tient 3 DOA Ott	her: 4 🗌 Nursing Ho	ome 5 Res	idence 6 🗆 Oth	ner (Specify)	
0	ding Phyeicien: h. After this certific funeral director,	:uo	27. Manner of Death 1 X Natural 5 Pending	28a. Date of (Month,	Injury 28b. Tim Day Year) Injur			28d. Describe	how injury occur	red	
SION	eath. or: A the fu	Certification:	2 Accident investiga	ation			Yes 2 No				
Ë	fter direct	ij	3 Suicide 6 Could not determine 4 Homicide	and 280. Place o	f Injury - At home, farm, j, etc. <i>(Specify)</i>	street, factory, office			(Street and Numb wn, State)	per or Rural Route Number,	
ב	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer			Bharisian Tark			<u> </u>				
	Hosp 24 ho Fune Fune	edical	29a. Certifier 1 Certifying (Check only 2 Medical E	rnysician: To the bas xaminer: On the bas and manne	est of my knowledge, d is of examination and/o	eath occurred at the ti r investigation, in my o	me, date and place, opinion, death occur	and due to the red at the time	cause(s) and ma date and place,	anner as stated. and due to the cause(s)	
	thin the	Mec	29b. Signature and title of certifier				se number		29d. Date signe	d (Month, Day, Year)	
	F 3 F 8		Maux	ijia-1	NO	000	40567		June 2	4 2004	
			30. Name and address of person v	no completed cause	of death (Item 23a) (Tv	pe, Print) (2CO1	Old Corner	end	Randon	Is bound to an and	-
	B		Many by Mejia	Nathwest	Hospitzii Ca	16V	on outpr	14000	rinaal	12 TOWN, Maryle	1/1/2
	Sta	ate	31. Date filed (Month, Day, Year)								
	Regist		HIM o ~	0000	gistrar's Signature						
DHI	MH 17 Rev 1/2	2001	3014 X 2	2004	w & A	and					
				v.	ORIGI	NAL					

		•	1 - For State Registrar	State of Ma	ryland		artment of F		Mental Hy	giene	nnı.	201	I. E
			Decedent's Name (First, Middle, La	ist)					2. Date of De	ath	0-13-	3. Time of	Death
	Physici		Ethel Yola	anda Traino					June	Day 23	2004		A M
	/Medic Examin		4a. Facility Name (If not institution, give				4b. City, Town, o	or Location of De	ath	4c.	County of De		
			Holy Cross Rehab	ilitation (Center	r	Silve	r Spring	J	Mo	ontgom	ery	
	Funeral			Sex 7. Age 1□M 2፟ØF	(In yrs. las		If Under 1 Year Months Days			pate of Birth Month, Day, Year) 9. Birthplace (State of Country)			or Foreign
	Director		151-03-7446	1LJM 2MF	87	Yrs.						w Jersey	
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, 7	Town or Lo	cation					10d. Inside C	ity Limits
	Aaryli Sho	ō	MD Howard		•	ırel							2 ∑ No
	28a-	Director	10e. Street and Number				10f. Zip Code			10a, Citiz	zen of What (Country?	
	Sa or		9110 Lilac Park	Drive				20723			USA	,	
	Jeath	Funeral	11. Marital Status	12. Was Decedent Ev	ver in U.S.	13. V			(Specify Yes or No erto Rican, etc.)). 1	14. Race - An	nerican Indian,	
တ	or Her	교	1.XX ever Married 2 ☐ Married	Armed Forces?	0				erto Rican, etc.)		Black, Wh	nite, etc.	
ĕ	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Madical Examination to molified at	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1	I⊡Yes 2XXXVo	Specify:			Specify:	White	
2	72 ho	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)		(Give	lent's Usual Occu kind of work done	during most of v	vorking	16b. Kir	nd of Busines	s/Industry	
2	ithin Ban Ban	dμ	Elementary/Secondary (0-12)	College (1-4or 5+	-)		OO NOT use retire	,			11.		
2	led w tygier her ti		17. Father's Name (First, Middle, Last	3 years		Regi	stered N		lame (First, Middle		ospita.	<u> </u>	
and	be fi	Be	John Traino	,					la (unkno		Sumame)		
Ž	hould d Mei nark	^L O	19a. Informant's Name/Relationship	Type Print)		10h Mailin	a Address (Street	L	Rural Route Numb		Town State	Zin Codol	
Maryland 21215-0036	d 2 s th an 17 ls r traur		Virginia Shannon	/ niece			-		ırt Laur	-			13
ē,	1 an Heal tem 2		20a. Method of Disposition	,	20b. Plac	e of Dispo	sition (Name of		Date			or Town, State	
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show array njury or other traumatic event. It is Mardical Examinet is at the mailled at ance.		1 ☐ Burial 2 ☐ Cremation 3¾ `4 ☐ Donation 5 ☐ Other (Speci		1	-	natory or other pla Cemetery		ne 26, 04	Pat	arean	, New Je	rcav
	nit. F		21. Signature of Funeral Service Lice			-			Donaldson				
Ö	Departing Concession		1 G73/560	/M	00770	- 49			ue, Laure				
i			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused t	the death.	Do not enti	er the mode of dyi	ng, such as card	liac or respiratory a	rrest,		Approximat Interval Bet	e waan
	Pnysician		Immediate Cause (Final disease or condition			Heart	Failure					Onset and I	Death
	/Medical		resulting in death)	Due to (or as a								J TOUL	
	Examiner	'n	Sequentially list conditions,	b. Dilated			opathy					10 Yea	2.6
	P =	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a								100	
	and and I-trans	Examiner	that initiated events resulting in death) Last	c. Recurri			ıtes			_		l Year	
8760,	ate be executed thysician and the burial-transit	aiE											
687	the the	dicai		_ d.									
ox (eath certific attending p	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o						2	3d. Date of d	elivery	
\mathbf{m}	death atter	clar	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at ti			lEctopic pregnanc Other <i>(specify)</i> _	у			Month		Year
o.	that the de ted by the a detached f	Physician/Me	9 Unknown	9□ Unknown									
ď	The law requires that the death certific ate has been signed by the attending Fagge 2 should be detached for use as	by P	Part II. Other significant conditions	•		ng in the ur	nderlying cause gr	ven in Part I.	23e. Did t	obacco us	se contribute	to the cause of d	leath?
Records,	w require been sig should b	ed	Generalized Athe	rosclerosis	3				1 🗆 '	Yes X	į̃No 3∏f	Probably 4 🔲	Jnknown
000	e law re has be je 2 sho	piet				,			24a. Was		24b. Were a	autopsy findings completion of c	available
m m		Completed							perfo	rmed?	death? 1 ☐ Ye	'	
/ita	ysician: Th is certificate director, pag	Be (25. Was case referred to medical examiner?						eath (Check only o	one)			
7	S S	2	1 ☐ Yes ŽŽXNo	Hospital: 1 Inpatien					Home 5 ☐ Resi			ecify)	
חכ	After UNBER	lon:	27. Manner of Death XXNatural 5 Pending	28a. Date of Injury (Month, Day	Year)	3b. Time of Injury	28c. Inju Wo M 1	ryat rk?]Yes 2 □ No	28d. Describe	now injury	occurred		
isio	death death stor: /	icat	2 Accident investigation 3 Suicide 6 Could not be	DB Dings of Injur	rv + At home	a farm str		1105 2 110	28f Location (Street and	l Number or i	Rural Route Num	her
Division of Vital	after Direction by	Certificat	4 Homicide determined	building, etc.	(Specify)	o, 141111, 0111	301, 140101), 011100		City or To	vn, State)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	70000170017	
_	Hospital		29a. Certifier Certifying P	hysicien: To the best of	f my knowle	edge, death	occurred at the ti	me, date and pla	ice, and due to the	cause(s)	and manner	as stated.	
	To the Mospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	(Check only 2 Medicel Exe	miner: On the basis of e and manner state	examination ed.	n and/or inv	estigation, in my	opinion, death oc	ccurred at the time,	date and	place, and du	ie to the cause(s)
	To the within 7 To the comple	X	29b. Signature and title of sertifier	0.004111	e V	۔۔۔	29c. Licens	se number		29d. Date	signed (Mor	nth, Day, Year)	
	0			aneym			D 1:	3677		June	23, 2	2004	
	4		30. Name and address of person who		<u></u>			_		_			
	~		B.G. Manejwala, M				ck Drive	Laurel	, Marylan	nd 2	0707		
	Sta Registi		31. Date filed (Month, Day, Year)	104 Janes	معر	19	sport.						

				For State	State o	f Marylai	•	artment of H	lealth and N	_	giene Reg. No 2	0.1	00		
				Registrar 1. Decedent's Name (First, Middle	, Last)			timouto or	Dodin	2. Date of De	ath	1.14	3. Time e	f Death	
		Physicia /Medic		Eleanora A.	Taylor					June	24, 2	004	5:10	Рм	
		Examin		4a. Facility Name (If not institution,	-				r Location of Death		4c. Count	y of Death			
				Evergreen Assi					timore If Under 24 Hrs.	1		N/A			
		Funeral		5. Social Security Number 219-10-1842	6. Sex 1 ☐ M 2 ☐ ¥F	7. Age (In yrs 19	. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Bir (Month, Da Nov. 9.	1924	9. Birthplace (State or Fo Country) 924 Maryland			
		Director		Usual Residence of Decedent						Nov. 9,	1724	Moocy	Lanu		
		ylano how		10a. State 10b. County		10c. C	ity, Town or Lo		+ 00.			1	0d. Inside C		
		Ba-f s	ctor	Maryland Baltin	iore			Upper	falls					2 X No	
		or 28	Director	10e. Street and Number	,			10f. Zip Code	21156		10g. Citizen of		itry?		
		eath v	erai	11211 Raphel R		edent Ever in l	19 13	Was Decedent of H		necify Ves or No	U.S.	ce - Americ	an Indian		
	10	after death with the Marylan or Itema 23e or 28a-f show other coust be rectilized at	Funeral	1 Never Married 2 Marri	Armed Fo	rces? 2 X No			lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Bla	ick, White,			
	036	ours a	þ	3 ☐ Widowed 4 💆 Divorced	If Yes, Gir Year or D	VB		1☐ Yes 2🕱 No	Specify:		Speci	ty: WV	iite		
	5-0	72 hc	etec	15. Decedent (Specify only highes	s Education t grade completed)		(Give	dent's Usual Occup kind of work done	during most of world	king	16b. Kind of I	Business/In	dustry		
	121	within 908. Ihan	ldmi	Elementary/Secondary (0-12)	College (1-4or 5+)	1	DO NOT use retired mbly Line	,		Shoe (Co.			
	d 2	filed Hygie other	Be Completed	6th Grade 17. Father's Name (First, Middle, 1	_ast)		1 11000	noicy Erone	18. Mother's Nam	ne (First, Middle,			100		
	Baltimore, Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. At them 27 is marked other than "natural", or item 27s or 28s-f show or other traumatic event, the Macifical Extending to other traumatic event event event.	To B	Edward I. Ru	ıtkowski				Paul	ine S	iewiersl	ri			
	ary	2 should have list mail	Ξ.	19a. Informant's Name/Relationsh				-	and Number or Ru		-				
	Σ,	and and and m 27 iner tra		Mr. James Brice	Taylor,					per Fall Date		21156			
	ore	ges 1 It of H or otl		20a. Method of Disposition 1 X Burial 2 ☐ Cremation		State 200.	cemetery, crei	osition (Name of matory or other place	ce)		20c. Location			nd.	
	Ħ	it. Pa		*4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service I		Sa	icred H	Cart of M	lary 6/28/	12004	Europa	Homo	wigza	.nu	
	Ba	permit. Pages 1 and 2 Department of Health a Important: It Item 27 is any injury or other trau once.		Z Sold Sold Sold Sold Sold Sold Sold Sold	400				ur Rd.				<i>J</i> J		
		·		23a. Part I. Enter the disease, or	complications that	caused the dea	ath. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory a	rrest,		Approxima	te tween	
		Pnysician		23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition											
		/Medical		resulting in death)	a. Due to	(or as a conse	-								
BE		Examiner	_	Sequentially list conditions.	b. — Due to	·									
-5	7	led Isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Dispass or Injury	Due to	(or as a conse	quence oi):								
	-	execu n and ial-trai	Exar	that initiated events resulting in death) Last	c. Due to	(or as a conse	quence of):								
5	190	Attending Physician: The law requires that the death certificate be executed rideal. Cator: Alter this certificate has been signed by the attending physicien and one that there this certificate shad be detached for use as the burial-transit by the funeral director, page 2 should be detached for use as the burial-transit.			d										
2	89	nding phruse as th	Physician/Medical	IF FEMALE:									-		
24	Вох	attendin for use	lan/	23b. Was decedent pregnant in the past 12 months?		oirth 2 ☐ Fet	tal déath 3[Ectopic pregnancy	y			ate of delive	-	Year	
9	0.	the a	ysic	1 ☐ Yes 2 No 9 ☐ Unknown	4∐Pregi 9☐ Unkn	nant at time of own	death 5L	Other (specify) _					,		
~	٥	that the died by the detached	y Ph	Part II. Other significant condition	ns contributing to d	eath but not re	sulting in the u	nderlying cause giv	ren in Part I.	23e. Did t	obacco use cor	tribute to th	e cause of	death?	
0	rds	w requires t been signe should be	ed by	Perinhen	arteria	l dis	ease			10	Yes 2□No	3 ☐ Prob	abiy 4 💢	Unknown	
Pauglo	Records,	aw rek as bee 2 shor	plete	/						24a. Was		Were auto	psy findings	available	
	R	The lavate has	Completed							perfo	ormed? 2 ⊠ No	death?	npletion of d 2□ No	24U36 U1	
4	Vital	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?					26. Place of Dea	th (Check only o	one)		Accies	tod	
3	of	Physi this c	2	1 ☐ Yes 2 No 27. Manner of Death			ER/Outpatier	IL SELDOM	COLUMN TO THE REAL PROPERTY OF THE PERTY OF	ome 5 Resi	dence 6 🗖 Ot how injury occu	her (Specif)	Livi	ig	
ġ	no	ding I h. After funer	tlon	1 Natural 5 □ Pendin 2 □ Accident investig	9	of Injury th, Day Year)	Injury	Wor	rk? Yes 2 □ No	200. Describe	now injury occu	1180			
à	Division	Attendi er death. ector: A by the fu	ertification:	3 ☐ Suicide 6 ☐ Could r	ot be 28e. Place			reet, factory, office			Street and Num	ber or Rura	l Route Nun	nber,	
Eleanora	Ö	tal or At s after d al Direct ed in by	Cert	4 Homicide	Dulid	ing, etc. (Spec	ary)			City or To	MT, State)				
W		To the Hospital or A within 24 hours after To the Funeral Directorpletely filled in by	dical (29a. Certifier 1 Certifyin (Check only 2 Medical	g Physician: To the Examinar: On the b	e best of my kr	nowledge, deat	h occurred at the till vestigation, in my o	me, date and place,	, and due to the	cause(s) and m	anner as st	ated.	s)	
		the h	Med	one) 29b. Signature and title of certifier	and mar	ner stated.	7	29c. Licens			29d. Date signi		·		
		7 W 7 0		255. Olgitature and title or calling) x: /	16			39297		21	5/02			
		1		30. Name and address of person	who completed cau	se of death (Ite	em 23a) (Type		1(01)		0/2	1/0-			
)		Dr. Michael Ro		. Jopp	a Rd.,	Balt., M	D 21234						
		Sta		31. Date liled (Month, Day, Year)	2004 32. F	egistrar's Sign	nature 4	1							
	26.	Registr	ar	2011.70	LUUT /	7		2000 Km	-						

			For Stata Registrar	State of M	laryland / Depa Cea	artment of H			ene 1 N2 0 0 L	20167
-	Physici	an	Decedent's Name (First, Middle,	1 1 3				2. Date of Death Month	Day Year	3. Time of Death
	/Medic	cal	4a. Facility Name (If not institution,	give street and number		4b. City, Town, or	Location of Deat	J'UNE	4c. County of Death	
	Exami	lei	Saint Joseph	•			Tows	on	Balt	imore
	Funeral Director		5. Social Security Number	5. Sex 1 M 2 ☐ F 7. A	ge (In yrs. last birthday) 73 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birth Con	nplace (State or Foreign unitry)
	and w		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	a-f sho	ctor	ms Balti	MORE	PA	1RKVIL	LE			1 □ Yes 2 No
	with the	Director	10e. Street and Number	1 - 81		10f. Zip Code	234	100	g. Citizen of What Cou	intry?
	ems 23	Funeral	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba		pecify Yes or No-	14. Race - Amer Black, White	
36	be filed within 72 hours atter death with the Maryland ntal Hygiene. So of then "natural", or Items 23a or 28a-1 show event, it a Medical Exam arringst be notified at	by Fu	1 ☐ Never Married 2 Marrie 3 ☐ Widowed 4 ☐ Divorced]No	1 ☐ Yes 2 No	Specify:	o r nour, oto.	Specify: W	rite.
21215-0036	72 hou	eted	15. Decedent's (Specify only highest		(Give	dent's Usual Occupa	during most of wo		Sb. Kind of Business/I	
2121	filed within Hygiene.	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	DO NOT USO POLIFOCO	?	1	Manufac	turing
	should be filed within the Mental Hygiene. marked other than matic event, the Mental than the matic event.	Be	17. Father's Name (First, Middle, L.	ast)			18. Mother's Nar	ne (First, Middle, Ma	lo (o 'c	7.
Maryland		10	19a. Informant's ame/Relationshi	p (Type, Print)	19b. Mailir	ng Address (Street	and Number or Ru	iral Foute Number, C	City or Town, State, Zi	ip Code)
	1 and 2 Health em 27 ther tra		Dorothy L. 20a. Method of Disposition	Uchic	20b. Place of Dispo	4 ORbita	antid.,	BARKV II	oc. Location - City or T	1334.
Baltimore,	98 to 1		1 Ø Burial 2 ☑ remation 3 4 □ Donation 5 □ Other (Spe		comotoni orai	matory or other place	nadens l	1 1	imonion	
Balti	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Li	censee 7	The second second second	2. Name and Addres	s of Facility	krimore	MD DIE	234.
			23a. Part1. Enter the disease, or c shock, or heart failure. List of	omplications that cause	ed the geath. Do not ent	ter the mode of dyin	g, such as cardia	APEC, 0800 or respiratory arres	<u>1</u> HARFORC 1,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)		ATHIC PUL	MONARY I	FIBROSI	S		Onset and Death
	/Medical Examiner				s a consequence of):					
	ed sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Ungerlying Cause (Disease or injury	b. Due to (or a	s a consequence of):					
o,	te be executed ysician and e burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or a	s a consequence of):					
68760,	icate be physici s the bu	dical		d.						
Box (eath certific attending p	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom 1 ☐ Live birth		Ectopic pregnancy			23d. Date of deliv	
0	at the dea by the at tached fo	yslci	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			Other (specify)			Month	Day Year
۵.	es tha	by Pr	Part II. Other significant condition	s contributing to death	but not resulting in the u	nderlying cause give	on in Part I.		cco use contribute to	
Records,	w requir been si should	leted						1 ☐ Yes 24a. Was an		bably 4 Unknown
Re	The tay ate has page 2	Completed						autopsy performe	prior to co	opsy findings available ompletion of cause of 2 □ No
Vital	Physician: This certitical ral director, p	Be	25. Was case referred to medical examiner?	Hospital:		other actions		th (Check only one)		
of		n; To	1 Yes 2 No 27. Manner of Death	1 Inpat	iury 28b. Time of	IL SEL DOX	4 L Isuising i	ome 5 Residence 28d. Describe how	e 6 □Other (Speci injury occurred	<u>fy)</u>
Division	Attending I r death. ector: Atter by the funer	catio	1 XNatural 5 ☐ Pending 2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	tion		M 1 🗆 '	res 2 □ No	29f Location /Ctmr	at and Alumbas as Cou	red Poute Number
Div	spital or Attend ours atter death veral Director: , tilled in by the f	Certification;	4 Homicide determin	ed building, 6	njury · At home, farm, str etc. <i>(Specify)</i>	eet, factory, office		City or Town, S	et and Number or Run State)	11 Houte Number,
	HO H T L ely	edical	29a. Certifier 1 Certifying (Check only one)	Physician: To the bes caminer: On the basis and manners	t of my knowledge, death of examination and/or in- stated.	n occurred at the tim vestigation, in my or	ie, date and place pinion, death occu	, and due to the caus rred at the time, date	se(s) and manner as s and place, and due t	stated. to the cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier	-1-	1/2	29c. License	number		. Date signed (Month,	
) Om		doub (ltc 00)		0263		06-22-	04
_	13		30. Name and address of person w	M D 76.0			ASON MG	RYLAND S	1204	
	Sta Registi	-	JUN 2 5 2004	32. Regis	trar's Signature	I to I was I was		The state of the s		
			JUIY & D ZUU4	- Comment	N DO	andal				

		•	For State Registrar	State of Maryland	-	artment of Health and I tificate of Death		giene Reg. N2 0 0 4	20148
			1. Decedent's Name (First, Middle, Last)			2. Date of Dea		3. Time of Death
	Physici /Medic		HANNEH BE	Atrice (10,111.	5	Jung 1	Day Year 5 200 4	8:30 A. M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or Location of Deatl	h	4c. County of Death	1
		•	LANG ROAD NURSI			BA Himone	T = 2	Na	
	Funeral Director		5. Social Security Number 6. Se 578 28 6356	7. Age (In yrs. I.	ast birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	(Month, Day	v, Year) Col	nplace (State or Foreign untry)
•			Usual Residence of Decedent	82			Smucky	12,1932 V	(A)
	show		10a. State 10b. County		, Town or Lo				10d. Inside City Limits
	a Ma	cto	MP M/a		Backing	ine			Yes 2 □No
	or 21	Dire	10e. Street and Number	,		10f. Zip Code		10g. Citizen of What Cor	untry?
	s 23a	Funeral Director	3508 Lynchester		10.1	21715	7 V N	U.5.A.	4 . 4:
	Itam Itam	inne	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S Armed Forces? 1 Yes 22 No		Was Decedent of Hispanic Origin? (S f Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White	
336	urs af	by	3 € Widowed 4 Divorced	If Yes, Give Year or Dates:	1	1 ☐ Yes 2 No Specify:		Specify: 614	LCK.
21215-0036	within 72 hours after death with the Maryland ene. then "neturel", or Items 23e or 28e-f show Ite Madical Examiliaer: sust be ristillist at	ted	15. Decedent's Edu	ication	16a. Deced	lent's Usual Occupation	duin n	16b. Kind of Business/	
218	thin 7	Completed	(Specify only highest grad Elementapy/Secondary (0-12)	College (1-4or 5+)	life. L	kind of work done during most of wor DO NOT use retired)			
	filad wi Hygien other th	Con	9	0	Hou	SEKEEPING		UNIVELS of If Maiden Surrame)	PENN
pug	be fill	Be	17. Father's Name (First, Middle, Last)					Maiden Surr∕ame) ∨	
Maryland	2 should be filad withir and Mental Hygiene. Is markad other than eumetic event, the M	ို	19a. Informant's Name/Relationship (T	ma Drinel	10b Mailie	MAKY ng Address (Street and Number or Ru		City of Town City 7	i- Codel
Ma	d 2 sl th an 17 is r treur	2	HELMON BUDINSON	rpe, Frintj			- 2	4 MD 2/3	
ē,	is 1 and 2 should be filad within 72 hours after death with the Maryla of Hauth and Mental Hygiene, item 27 is marked other than "neturel", or Items 23e or 28e-f show item 27 is marked other than "neturel", or Items 25e or 28e-f show other treumetic event, the Medical Examinations usit be medified at		20a. Method of Disposition	20b. Pl		sition (Name of natory or other place)		20c. Location - City or 1	
altimore,	permit. Pages 1 ar Department of Has Important: If item eny injury or othe once.		1 Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,				lace .	Baldanie	
Ħ	permit. F Departmo Importar eny injur		21. Signature of Funeral Service Licens	-	22	. Name and Address of Facility $\mathcal{B}_{\mathcal{E}}$	As Fune	not tume	
ä	Department Department Important in conce	M 3	Natura B	od		129 NI CARELINE 3			13
	-		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death		er the mode of dying, such as cardiac			Approximate Interval Between
	Physician	8	Immediate Cause (Final disease or condition	Coreboro	VENTA	lan accide	nt		Onset and Death
	/Medical		resulting in death)	Due to (or as a consequ	-	Astry Di			
п	Examiner		Sequentially list conditions,	b. Christian	y	thury Di	Rase		
	ed isit	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ende of):	2 7-0			-
	be executed iician and burial-transit	xan	that initiated events resulting in death) Last	c. Due to (or as a consequ	ence of):	yearing			
8760	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical E		Deme	entre	2.			
9	ificate g phys as the	edic		0.					
Box	death certific attending pl	M/u	23b. Was decedent pregnant	23c. If yes, outcome of pregnar		Ectopic pregnancy		23d. Date of deliv	very
-	ed for	sicis	in the past 12 menths? 1 ☐ Yes 2 ☑ No	4☐Pregnant at time of de		Other (specify)		Month	Day Year
P.0	that the de led by the a detached t	Physician/Me	9 Unknown		Marie Comb		OD- Dida		
	ires tha signed d be de	by	Part II. Other significant conditions co	ntributing to death but not resu	iting in the ur	nderlying cause given in Part I.		bacco use contribute to les 2 □ No 3 □ Pro	
0.00	w requir been si should	Completed							
3ec	ne law has l	mpi					24a. Was a autops perfor	an 24b. Were aut sy prior to co med?/ death?	opsy findings available empletion of cause of
a			Or Wassesser				1□ Yes	2₽No 1□Yes	2 □ No
of Vital Records,	Physician: this certific	o Be	25. Was case referred to medical	Hospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatien	0.1	th (Check only or	ne) ence 6 □Other (Speci	-
	Phys ar this eral di	n: To	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. injury at		ow injury occurred	<i>'ly)</i>
ion	nding lath. ath. r: Aftar e funer	atio	1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Work? M 1 ☐ Yes 2 ☐ No			
Division	or Attending after death. Director: Aftar in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho- building, etc. (Specify	me, farm, stre	eet, factory, office	28f. Location (Si City or Town	treet and Number or Run	al Route Number,
	ospital or Attendi hours after death. uneral Director: A ly filled in by the fu	Cer							
	To the Hospital or Attending Ph within 2- hours after death. To the uneral Director: Aftar th complet: ly filled in by the funeral	edical	(Check only 2 Medical Exam	iner: On the basis of examinat	vledge, death ion and/or inv	n occurred at the time, date and place restigation, in my opinion, death occu	, and due to the c rred at the time, d	ause(s) and manner as : late and place, and due t	stated. to the cause(s)
	To the h within 2. To the complete	Med	29b. Signature and title of certifier	and manner stated.		29c. License number	2	29d. Date signed (Month,	Day Vear)
\	T w S		Constitution and this of continue	elen		D 31464		6/17/0	
	m		30. Name and address of person who c	ompleted cause of death (from	23a) (Type	Print)			/
			SHDAIIS A. I	1 mt18ts	2211	U. EYTAW S	T fint	2308 B	almore M)
	Sta	ite	31. Date filed (Month, Day, Year)	32/Registrar's Signat	ure				21211
ь	Regist	ar	JUN 2 5 200	4 Jacobs 10	CON.	ME			

ALICIA WILLIAMS UNK 04-078	
04-01831	
DT	

I-01831		1	For State	State of Ma	aryland / Dep	artment of		-	giene Reg. NØ.	01.	20110
Phys	siciar	_	Registrar Decedent's Name (First, Middle, Last ALICIA NAPPER			- Inouto or	Dodin	2. Date of De Month	ath Day	Year	3. Time of Death
6	edica mine	4	a. Facility Name (If not institution, give			4b. City, Town, Bette	or Location of De	March	13, 2004 1030 A. 4c. County of Death Kent		
Fune Direct			Curners Creek Social Security Number 186–28–5211	x 7. Ag □M 2∏F	e (In yrs. last birthday 66 Yrs.		If Under 24 H	drs. 8. Date of Bir (Month, Date 7-7-1	th ly, Year)	9. Birth	place (State or Foreign intry) NA •
Aaryland f show		1	Jsual Residence of Decedent 10a. State 10b. County PA DAUPH	[N	10c. City, Town or L						10d. Inside City Limits 1 ☐ Yes 2 ☐ No
with the A 3e or 28e-	otoeto!		10e. Street and Number 461 CUMBERLAND			10f. Zip Code)		10g. Citizen of		intry?
ore, Maryland 21215-0036 Is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, tiem 21 is marked or her then "naturel", or Items 23e or 28e-1 show	Py Figure 1	2	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Amed Forces? 1 ☐ Yes 2 X II Yes, Give Year or Dates:	Ever in U.S. 13.		Hispanic Origin? oan, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	14. Ra Bla		
Maryland 21215-0036 nd 2 should be filed within 72 hours af the and Mental Hygiene. 27 is merked other then "naturel", or rrenumatic event, If a Merical Even.	potologi	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		(Give life.	edent's Usual Occu e kind of work done DO NDT use retire	pation during most of v ed)	working	16b. Kind of I		ndustry OVERNMENT
rland 2 uld be filed Aental Hygi rked other	Todo	2 -	17. Father's Name (First, Middle, Last) JUNIOR GRAY	_0			,	Name <i>(First, Middle</i> CE URRUTI	, Maiden Suma		7 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
e, Maryla 1 and 2 should Health and Men em 27 is marke		_	19a. Informant's Name/Relationship (T RICHARD WILLIA)) 46:	1 CUMBERI	AND COU	RTS HARRI	SBURG,	PENNA	A 17102
Baltimore, permit. Pages 1 ar Department of Hea Importent: If item:	once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 4 ☐ Donation 5 ☐ Other (Specify, 21. Sign June 1 Function 1))	CONOLITE TO D. HIBNER	watory or other pla VAULT CC . Name and Addr	CREM.		IELD FU	ERSTOV INERAI	WN, PENNA L HOME
Fnysicia /Medic Examin	al		23a. Part Lenter the disease, or comp shook or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a Due to (or as	the death. Do not enne. Mult a consequence of):	-	_			ravu'y	Approximate Interval Between Onset and Death
icate be executed physician and sittle burial-transit		LY G	n any, leading to it mediate cause. Enter Underlying Cause (Disease or injury	c.	a consequence of):						
O. Box 6 the death certif y the attending ched for use as	M/aci	Ξ	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pregnand □ Other (specify)	Ç y			ate of deliver	rery Day Year
cords, P. w requires that been signed by	1	<u>ק</u>	Part II. Other significant conditions co	ontributing to death b	ut not resulting in the t	underlying cause gi	ven in Part I.		obacco use cor Yes 2□No	atribute to t	the cause of death?
Vital Reco	1 8							24a. Was autor perfo	an 24b. osy rmed? 2 \(\text{No} \)	prior to co death?	opsy findings available ompletion of cause of
on of ding Phys After this		0	25. Was case referred to medical examiner? XXX Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 ☐ Inpatie 28a. Date of Inju (Month, Da	y Year) 28b. Time (of A 28c. Inju	her: 4 \sum Nursing			rred	WSCONE
DIVISIC pitel or Attencturs after death arel Director:		Cermication	3 Suicide 6 Could not be determined	28e. Place of Inj building, et Fc wil	ury - At home, farm, si c. (Specify)	treet, factory, office		Turner's	vn, State) Creek	Kent	al Route Number, + (cinty, M)
To the Hospitel within 24 hours a To the Funeral I		edic	29a. Certifier 1 Certifying Phy (Check only 2 Medical Examone) 29b. Signature and title of certifier	iner: On the basis of and manner sta	of my knowledge, dea f examination and/or in ated.	29c. Licen	opinion, death oc	ocurred at the time,	date and place, 29d. Date signs	, and due to ed (Month,	o the cause(s) Day, Year)
F > F 0	6		Zaluin 30. Name and address of person who	Clark	leath (Item 23a) (Type		OCME Penn Stre	100	April 2		004 Land 21201
Reg	State	· ·	2431ULC 4 31. Date filed (MJUN 2 ^V 937) 201	32. Ragistr	ar's Signature						
DHMH 17 Rev		- 3			we &	spar.	i e				

	76 DEWHI	TAF	unpend item#23a,27,2 Please AMEND ITEM #20	8a-f, PER ME, C833, 7 Type or Print in I DB, PER FH, C836, State of Marylar	7/22/04eq Black In 10/14/	g delible Ink. Ensur 04 TT	re All (Copies Are	Legible.	
WHM			1 - For State Registrar	State of Marylar		irtment of Health al tificate of Death	na mei	ntai Hygien Reg. M	2001	20150
	Physici	an	1. Decedent's Name (First, Middle, La	ast)	Lak	2 ~		Date of Death Month JUNE 16,	^{ay} 2004 ^{Year}	3. Time of Death 6:20 P M
	/Medio	cal	4a. Facility Name (If not institution, given	ve street and number)	IMA	4b. City, Town, or Location of			c. County of Death	0.20 F W
			306 LYNDHURST ST 5. Social Security Number 6.	Sex 7. Age (In yrs.	last hirthday)	BALTIMORE (Date of Birth	NI	A (State or Foreign
	Funeral Director		2/2-76-2117 Usual Residence of Decedent	1×M 20F 45	Yrs.	Months Days Hours		(Month, Day, Year	158 Mic	place (State or Foreign ntry) US Yland
	ath with the Marylan s 23a or 28a-f show ust be neithed at	Funeral Director	Mary and 10b. County 10e. Street and Number	A 10c. Ci	Balt	action MOPE 10f. Zip Code		10g C	itizen of What Cou	10d. Inside City Limits 1 Yes 2 □ No
	th with 23a or	ai Dir	220 Mt. F	folly St.		21229		, og. c	USt	7
	itams	uner	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No	.S. 13. \	Vas Decedent of Hispanic Origi f Yes, specify Cuban, Mexican,	in? (Specify Puerto Ric	y Yes or No- an, etc.)	14. Race - Ameri Black, White,	
9036	ours aft	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1	□ Yes 2 1 No Specify:			Specify: B	ack
21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is markad othar than "natural", or itams 23a or 28a-f show aumstic event, the Medical Examination of the confilment at	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	Education rade completed) College (1-4or 5+)	/Give	lent's Usual Occupation kind of work done during most (OO NOT use retired)	of working	16b. 1	Cind of Business/In	dustry
Maryland 2	s 1 and 2 should be filed within Health and Mental Hygiene. Itam 27 is markad othar than ' other traumatic event, The Me	To Be C	17. Fatty r's Name (First, Middle, Las	VhitaKer.		18. Mother	's Name (F	irst, Middle, Maide beth	Lynn	9
Mar	id 2 sho lth and 27 is m traum		19a. Informant's Name/Relationship	(Type, Print) (Wife)	19b. Mailin	g Address (Street and Number	or Rural R	loute Number, City	or Towd, State, Zip	Code) 21158
	ges 1 and t of Health If itam 27 or other to		20a. Method of Disposition 1 🗆 Burial 2 🗶 Cremation 3 [20b. f	Place of Dispo	sition (Name of natory or other place)	Date	20c. L	ocation - City or To	own, State
Baltimore,	t. Pa rtmen rtant: njury		*4 □ Donation 5 □ Other (Special Street of Funeral Service Lice	ity) G	reen		/30/0	4une t	Balto.	Md.
Ba	permit. Departi import any inj once.	lo 3	1 10ph	L. Bus	1 50	Name and Address obsacility SEPH L. RUS ZZZW. NOCTA	SS I	Tusera	Home	216
	Pnysician /Medical Examiner		23a. Part 1 Enter the disease, or consider, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	y one cause on each line.	l Narco	er the mode of dying, such as c		espiratory arrest,		Approximate Interval Batween Onset and Death
-	pe sit	aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consec	quence of):					
68760,	iicate be executed physician and s the burial-transit	edicai Exam	Cause (Disease or injury that initiated events resulting in death) Last	c	quence of):					
P.O. Box 68	The law requires that the death certificate be ex ate has been signed by the attending physician . page 2 should be detached for use as the burial	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn. 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o	al death 3	Ectopic pregnancy Other (specify)	7		23d. Date of delive Month	əry Day Yəar
Is, P	res that signed b	by	Part II. Other significant conditions	contributing to death but not res	sulting in the u	nderlying cause given in Part I.			use contribute to the	
Records,	The law require cate has been signage 2 should b	ompieted						24a. Was an autopsy performed?	24b. Were auto prior to co death?	psy findings available impletion of cause of
× Nital		Be C	25. Was case referred to medical examiner?			26. Place o	of Death (C	10 Yes 2 No Check only one)	0 1 THE	2 No
0	Phys this ral di	P	XXYes 2 No 27. Manner of Death 1 Natural 5 Pending	Hospital: 1 Inpatient 2 Inpati	28b. Time of	28c. Injury at	28d	5 Residence Describe how inju		y) SCENE
Division	i or Attanc after death Diractor:	Certification:	2 Accident Investigation 3 Suicide 6 Could not determined	be Osa Blace of Injury At h			28f.	Location (Street a	e)	022022
Q	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	-c3	29a. Certifier 1 Certifying P	found in reside	nce owledge, death	occurred at the time, date and	place, and	b Lynchurst	St.,Baltir	tated.
	tha H Ithin 24 o the F	Medic	one) 29b. Signature and the of certifier	and manner stated.		29c. License number	r occurred t		ate signed (Month,	
	1 3 F 8		Thanks e	1 King ms		OCME			E 17, 20	
	16,00		30. Name and address of person who		п 23а) (Туре,	Print) 111 Penn St	reet	Raltimor	na Marari	and 21201
10	- Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa			LUCL	TOTAL CHILD	.c, ratyl	MRA ZIZVI
	Regist	rar	JUN 2 5	2004 Segue.	K A	neck				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rag. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) $200\overset{\text{Year}}{4}$ **Physician** JUNE 19, 1809 PM HARLES LA C 50 REE /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** BALTIMORE CITY SINAI HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Month, Day, Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** M 2□ F Yrs. Director 38 -772c Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Directo BAL Werly Tero TORE 500 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a ZIHGIZ 2116 . [4 8410 by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or Items 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes ZNo Specify: Specify: 3 Widowed 4 Divorced WHI Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene.
7 Is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) SEPER GROUNDS or other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be Department of Heath and Mental Important: If item 27 is marked tany injury or other traumatic even +REDIRICK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 118 ETT 8FIT BURNIE MALESAI 1 BIHTURZ 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition cemetery, crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Funer Servic Licens 21334 Duce. BBOO HARFORD ROFO 20AV3 1ARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician CARDIAC TAMPONA DE /Medical Due to (or as a consequence of) Examiner DISSECTION PUPTURED AORTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine burial-transit ATKEROSCIENTIC CARDIOVAL and that initiated events resulting in death) Last requires that the death certificate be exec Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760; signed by the attending physician d be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 DEctopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ★ Yes 2 □ No page 2 autopsy performed? 12 Yes 2 🗆 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 XYes 2 □ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after within 24 hours The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the dause(s) and mainly as subject to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) JUNE 20, 2004 29c. License number 29b. Signature and title of certifier O.C.M.E 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANA PUBIC 111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 2 5 2004 Registrar

			State of Maryland / Department of Health and Ment 1- State Registrar Certificate of Death	tal Hygier	2001	20152
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980	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene item 27 la markad other than "natural", or Items 23a or 28a-1 show other traumatic event, If a Marical Execution rust be inclifted at	þ	3 Widowed 4 Divorced If Yes, Give Year or Dates: 1949-1957 1 Yes 204No Specify:	Yes or No- n, etc.)	14. Race - Ame Black, Whit Specify: V	
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Baltimore	permit. Page Department o Important: If any injury or once.		*4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility EVAN	2004 P	ARKVILLE, PELOF M	MARYLAND EMORIES
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$\mathbf{\alpha}$		Completed		4a. Was an autopsy performed?	24b. Were au prior to death?	topsy findings available completion of cause of 2 No
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/Medic Examin		George Hosie 4a. Facility Name (If not institution, g				4b. City, Town, o	r Location o	June Death		COU4 lc. County of De	
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Funeral		,	Sex 7		last birthday) Yrs.	If Under 1 Year Months Days					
Director		212-28-8161 Usual Residence of Decedent		76	115.			Mar.	9, 19	28 No	rth Caroli
Mot		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation					10d. Inside City Lim
a-f st	ctor	Maryland Harford	Ē	Ha	wre de	Grace					1 □ Yes 2 🌠
or 28	Director	10e. Street and Number				10f. Zip Code			10g. C	Citizen of What	Country?
1 23a		4032 Webster Road				21078			US	A	
"natural", or items 23a or 28a-f show suical Examinst must be natified at	Funeral	11. Marital Status	12. Was Deceder Amed Force	s?	J.S. 13. 1	Was Decedent of H f Yes, specify Cuba	lispanic Orig an, Mexican,	in? (Specify Yes o Puerto Rican, etc	or No-	14. Race - Ar Black, WI	merican Indian, hite, etc.
r, or	by F	1 ☐ Never Married ♣️☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2X If Yes, Give Year or Date:			1 ☐ Yes 2 No	Specify:			Specify:	Calle d' L. e.
atura Gal E		15. Decedent's	Education		16a. Deced	ient's Usual Occup	ation		16b.	Kind of Busines	White ss/Industry
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For A State Registrar

	1. Decede
Physician	
/Medical	
Examiner	4a. Facility

Director

Completed by Funeral

10:10 AM

10d. Inside City Limits

1 ☐ Yes 2 😿 No

N/A

U.S.A.

WHITE

STOFBERG

Funeral

Director

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Physician /Medical Examiner

burial-transit or Attanding Physician: The law requires that the death certificate be executed detached director, page 2 should death. after death filled in by the 24 hours a

Box 68760

P.O.

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Division of Vital

Be ပ္ Physiclan/Medical Examiner à Completed Be Certification; To 29a. Certifier Medical

State of Maryland / Department of Health and Mental Hygiene 7,9,30, per FH/DVB-G832 06/25/04/4hb 2. Date of Death ent's Name (First, Middle, Last) , 2004 Year JUNE 21, WEISMAN THELMA Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death LEVINDALE HEBREW HOME BALTIMORE 8. Date of Birth 8/16/1918 inthplace (State or Foreign Country)

MD

MD If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours Min 1 ☐ M 2 🙀 F 85 87 Yrs. 212-12-4839 Usual Residence of Decedent 10a. State 10c. City. Town or Location 10b. County BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3902 BUCKINGHAM ROAD 21207 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 X Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NURSE MEDICINE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) FELDMAN SOL SOPHIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3902 BUCKINGHAM ROAD - BALTIMORE, MD 21207 BELLE KLINE / SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State ANSHE EMUNAH AITZ CHAIM 6/24/2004 * 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 21. Signature of Funeral Se 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify)

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23e. Did tobacco use contribute to the cause of death? 2 0 3 Probably 4 Unknown 1 Tyes

24a. Was an autopsy performe 1 Tes

24b. Were autopsy findings available prior to completion of cause of death? 2[] No 1 Yes

25. Was case referred to medical examiner? examiner? Manner of De 1 Anatural 2 Accident

3 🗀 Suicide

4 Homicide

5 Pending investigation 6 Could not be determined

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

ributing to death but not resulting in the underlying cause given in Par

Other: 4 Jursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

3FT DOA

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and many gristated. (Check only one) 29b. Signature a

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) lune 21, 2004

use of death (Item 23a) (Type, Print)

Susan M. Levy, M.D., Levindale Nursing Home

31. Date filed (Month, Day, Year) State Registrar

HIN 2 5 2004

32. Registrar's Signature

Fo tha

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.) 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year Alvarez June 9 2004 9:39 Α Manuel /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Prince Georges Laurel Regional Hospital Laurel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Davs | Hours | Min. | (Month, Day, Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1□M 2□F Months 218-66-2812 Director 89 Yrs. 28,1915 Cuba Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 28e-f show treumatic event, the Madical Examiner must be notified at 1XYes 2 No Completed by Funeral Director Montgomery Silver Spring 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "netural", or Items 23a or 2 any Injury or other freumatic event, the Modical Exampling must be no once. 10f. Zip Code 10g. Citizen of What Country? 12801 Maple Street 20904 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Cuban 1 ☑ Yes 2 ☐ No Specify: Specify:White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Groundskeeper University 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be P Jose Delao Alvarez Ramona Vasconcelos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12801 Maple St. Cecelia Alvarez/Daughter Silver Spring, Md 20904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Miami, Fl ^ 4 □ Donation 5 □ Other (Specify) Woodlawn Park South 6-14-04 22. Name and Address of Facility Fleck Funeral Home Inc, 21. Signature of Funeral Service Licensee enca TRUDUT MO133X 7601 Sandy Spring Rd. Laurel, Md 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Coronary Artery Disease Years disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 attending physician Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1□Live birth 2□Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Renal Failure, Metabolic Encephalopathy, Sepsis 1 Yes 2 No 3 Probably 4√JUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one) Other: 2 1 ☐ Yes 2 ☑ No 1

Inpatient 2 □ EP/Outpatient 3 □ DOA this 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification; 28d. Describe how injury occurred Director: After 5 Pending Injury 1 XNatural death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) in by 4 🗋 Homicide within 24 hours a To the Funerel C 🖰 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) D23181 June 9, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R. Bhojraj, MD 704 Gorman Avenue, Ste T-l Laurel, Md 20707 32. Registrar's Signature State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) JUNE 22, 2004 **Physician** 5:32 P M Jonathan David Adams /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL CO | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Min. | April 13,1961 | Maryland 5. Social Security Number 6. Sex 14 M 2 □ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Yrs. 43 218-78-4958 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show other traumatic event, the Mydical Examinar must be notified at 1 Yes 2 □ No Director Maryland Anne Arundel ${ t Annapolis}$ 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ŏ United States 21403 603 Americana Drive 238 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ñ No If Yes, Give Year or Dates: Items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Specify: White ō 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4X Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event the many injury or other traumatic event the manual contract. Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Deli Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Novella Capps Frank M. Adams ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Adams / Brother 18619 Brooke Road Sandy Spring Maryland 20860 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 6/24/2004 Baltimore, Maryland Baltimore Crematory ⁴ □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 1/Wester Annapolis, MD 21401 147 Duke of Gloucester St. 23a. Part1. Enter the disease, or complications in bt caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final Priysician 6/3/W disease or condition resulting in death) /Medical Due to (or as a consequent of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine use as the burial-transit certificate be executed Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 ☐Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 □ No 24a. Was an certificate has Yes 2 🗌 No Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 【XER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 □ No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Hospital or Attending 1 Natural 2 Accident 5 Pending death. 1 🗌 Yes investigation after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the within 2 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 1/2001

address of person

JUN 2 8 2004

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

OCME

JUNE 23, 2004

111 Penn Street, Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Year ABRAHAM ALEXANDER 7:30 PM 06 7 12004 /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner BALTIMORE GOOD SAMARIMAN HOSPITAL N/A If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 6-8-30 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 S.C. **Funeral** 10XM 2□ F 247-48-3168 Director 74 Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show if of Health and Mental Hygiene.
If item 27 is marked other than "natural", or itema 23e or 28a-1 shov or other traumatic event, it a Medical Exactinar must be notified at Md. NA Baltimore 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4700 Harford Rd. 21214 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filled within 72 hours after 1X Never Married 2 ☐ Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 🎇 No Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sewage @ Waste 7th grade Baltimore City 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Alexander Almena 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4637 Rokeby Rd., Baltimore, Md. 21229 Alfred Marcus Nephew 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, Stete permit. Pages t Department of H Important: If Ite any injury or ot once. cemetery, crematory or other place)
Arbutus Mem. PK. 1 XBurial 2 Cremation 3 Removal from State 6-24-04 Arbutus, Md. * 4 ☑Donation 5 ☐ Other (Specify) 21. Eignature of Funeral Service License 22. Name and Address of Facility Baltimore, Md. 21202 1101 E. North Ave. March F.H. East 23a. Pirt1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ho it or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Im redian Cause (Final disease ir condition resulting in death) RESPIRATORY Physician FAILURE /Medical Due to (or as a consequence of): Examiner ATERAL Securations list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. signed by the attending physician be detached for use as the buria Completed by Physician/Medical N/A IF FEMALE: 23c. Il yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death Day Year 5 Other (specify) Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? certificate has b irector, page 2 s 24a. Was an autopsy performed Division of Vital 1 ☐ Yes 1 ☐ Yes P☐ No 2 No Hospital or Attanding Physician: director 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes P No 2 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 0-Natural death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (CHECK UNIT To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) & S. Thomas MD D0060687 30. Name and address of person who completed cause ol death (Item 23a) (Type, Print) SONY M THOMAS MD, GOOD SAMARITAN HOSPITAL 31. Date liled (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

JUN 2 8 2004

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2004 **Physician** EDNA DOROTHY BARNHOUSER June 25, 4:00 A M /Medical 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) 4c. County of Death Examiner 8. Date of Birth Month, Day, Year Mariner Health and Rehabilitation Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 79 Yrs. 9. Birthplace (State or Foreign **Funeral** Mary land 219-18-5243 Director Usuel Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at Mary land Anne Arundel Baltimore 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 212 Fourth Avenue 21225 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify ģ White 3 XWidowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Hygiene. Housewife & Mother Homemaker permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy
Important: If item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edna D. Reibert William Α. Reis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Atty. Michael J. Dausch III (Executor) 6741 Glenkirk Rd., Balto., Md. 21239 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem Pk 6/28/2004 Glen Burnie, Maryland *4 □ Donation 5 □ Other (Specify) 21. Signature of Fundral Service Licensee McCully-Polyntak Funeral Home, P.A. 237 E. Patapsco Ave., Balto., Md. 21225-1856 once. Kevin E Ecker 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 8 DAY /Medical Due to (or as a consequence of) Examiner PHIOXICROSK Soll Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner certificate be executed the attending physician and ned for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Ö detached 交 ٦ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à eq 1 Yes 2 No 3 Probably 4 Nonknown page 2 should Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 Yes 2 No 1 Yes Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death Check on one Be examiner' Hospital: 1 Inpatient Other: 1 ☐ Yes 2 🔣 No ۵ 2 ER/Outpatient 3 DOA 4 ursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place ol Injury - At home, larm, street, factory, office building, etc. (Specify) in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CH CH 31. Date liled (Month, Day, Year) 32. Registrar's Signature State JUN 2 8 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician JUNE 22, ^D2004 Mary Μ. Buck 1:56 МФ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Franklin Square Hospital Rosedale Baltimore 5. Social Security Number | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 218-32-5451 66 Director Feb. 28, 1938 Maryland Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location show 10d. Inside City Limits 7 is marked other than "neturel", or items 23e or 28e-f shov traumatic event, the Medical Exemiter must be rivilled at Maryland Baltimore Middle River 1 TYes 2 XNo Directo 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 9730 Conmar Road 21220 U.S.A. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 2 should be filed within 72 hours after n and Mental Hygiene. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 2 Specify: 3 MWidowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Assistant Manager Grocery Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Spinnichio Elvera Pavone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Dept.rtment of Health and Important: if item 27 is n any njury or other traun once. Bob Miller (Son-in-law) 9730 Conmar Road, Baltimore, Maryland 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State tX Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens Of Faith ¹ 4 □ Donation 5 □ Other (Specify) June 28,2004 Baltimore, Maryland 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A. 21. Signature of Funeral Sector Ucensee 1407 Old Eastern Avenue, Essex, Maryland 21221 ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final diseas for condition Physician Cardiopulnonary Arrest 30 MINUTES resulting in death) /Medical Due to (or as a consequence of): Examiner WITH Hypertension 10 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner certificate be executed the burial-transit that initiated events signed by the attending physician and resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical as ₽S⊓ 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery The law requires that the death 3 ☐ Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 No be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 PHYSEMA 1 ☐ Yes 2 ☐ No 3 Probably 4 Minknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes Division of Vital 2X No I or Attending Physicien: after death. Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3□ DOA funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 X Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel E Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D18842 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Jeffrey Pargament, 9518 Philadelphia Road, Suite B, Baltimore, Maryland 21237 31. Date filed_(Month, Day, Year) 32. Registrar's Signature State JUN 2 8 2004 Registrar

			For State Registrar		State	of Mary	land / De	artmer			and M	-	-	1001	·· •	010	- 0
			Registrar 1. Decedent's Name (First, Mid	dle las	t)			rillical	e or i	Dealii		2. Date of De	Reg. No	UUU	6.	3. Time of E) U
	Physicia	an										Month JUNE 26	Da			1500	М
	/Medic Examin		DOROTHEA D. BLOT 4a. Facility Name (If not institut			mber)		4b. City	Town, or	r Location o	of Death	JOINE 20	-	. County of D	eath	1300	
	Examin	er		, y		,								•			
	Funeral		5. Social Security Number	6. Se		7. Age (II	yrs. last birthda	() If Unde		If Under		8. Date of Bir	th	ANNE ARU	Birthplac	e (State or	Foreign
	Director		214-54-8319	1[⊐м % Я F	6:	3 Yrs.	Months	Days	Hours	Min.	JULY Z4,	1 ^y .1 ^y 94() (ERMAK	AY.	
	pt.		Usual Residence of Decedent			140											
	aryia ahov	-	10a. State 10b. Cour	1			c. City, Town or								10d.	. Inside City	
	he M	ectc	MD ANNE	ARUNI)EL	G	LEN BURNIE									1 Tes	54A NO
	with t	5	10e. Street and Number					10f. Zij						tizen of What			
	eath	by Funeral Director	200 AQUAHART RD.		12. Was Dec	edant Eva	rin II S		1061	Ispanio Ori	nin2 /Sn/	ecify Yes or No	-	JNITED S			
	ter d	-un-	1 Never Married 2 M	arried	Armed F	orces?	1110.5.	If Yes, spe	cify Cuba	an, Mexican	, Puerto	Rican, etc.)		Black, W			
99	urs al	by	3√Widowed 4 □ Divorc	T I	1 ☐ Yes If Yes, G Year or [ve XX Dates:		1 🗆 Yes	2□ No XX	Specify:				Specify:	WH	HITE	
Ö	within 72 hours after death with the Maryland ene. than "natural", or Itams 23s or 28s-f show he Medical Examinat must be multied at	Completed	15. Deced	ent's Edi	ucation		16a. Dec	edent's Usu	al Occup	ation	4 = 4 = dei		16b. K	ind of Busine	ss/Indus	stry	
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	e filed within al Hyglene. other than '	Con	12			4		HOMEM	AKER					OWN HOM	IE		
lnd	0 2 0 0	Be	17. Father's Name (First, Middi	e, Last)						18. Mothe	er's Name	(First, Middle,	Maider	Sumame)			
yla	should be ind Menta inarked imarked	은	200	HM I D					-	unk			PFEL				
Maryland	12 sh h and 7 la n treun		19a. Informant's Name/Relatio		ype, Pnnt)			•				d Route Numbe		or Town, State	e, Zip Co	ode)	
	s 1 and 2 should of Health and Meritem 27 Is market other treumatic		MIKE BLOTTENBERGI 20a, Method of Disposition	:R	-	SON	200 20b. Place of Dis	AQUAHA oosition (Na.	RT RD	. CLEN	BURN	E, MD 21		ocation - City	or Town	State	
ē	Pages nent of I int: If it		1 ☐ Burial 2 ☑ Crematio			I .	cemetery, ci					1				i, Olalo	
Baltimore,	- 분분군		' 4 ☐ Donation '5 ☐ Other 21. Signat → 6 Funeral Service		^		BAYVIEW C	REMATOR' 22. Name ar			004 06	5 28	BALT	IMORE, M	1D		
Ba	permi Depa Impo any i		Cuerquel	0-	- h	/		FINK FU	NERAL	HOME,	P.A.						
			23a. Partl. Enter the disease, shock, or heart failure.	or comp	lications that							BURNIE, M or respiratory ar		061	A	pproximate	
	Pnysician		Immediate Cause (Final	sul only o	one cause on	each line.	- 1							10.10		terval Betweenset and De	eath
	/Medical		disease or condition resulting in death)	-	a	(o) as co	onsequence of):	5100	C	1070	ny	Artery	יעו	Sease	u	رد ماریما سد	on
	Examiner		0 0 0 0 0 0 0 0 0 0		b												
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	•		(от ав а в	insaquance of):										
	acute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last		c												
3760,	ate be executed physician and the burial-transit	Ä	resulting in death) Last		Due to	(or as a co	nsequence of):										
	icate t physic	dlcal			d												
9 x	leath certific attending pl	/Me	IF FEMALE:		23c. If yes, ou	tcome of n	regnancy										
Вох	atten for u	ian	23b. Was decedent pregnant in the past 12 months?		1 Live		Fetal death 3	□Ectopic p						23d. Date of Month	delivery Da	y Ye	ar
P.0.	The law requires that the death certifics ate has been signed by the attending pt page 2 should be detached for use as t	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		9□ Unkr		o or douth - c	Comer (s)	, oc., y								
	that	by Pr	Part II. Other significant cond	tions co	ntributing to o	leath but no	ot resulting in the	underlying o	ause give	en in Part I.		23e. Did to	obacco i	use contribute	to the c	ause of dea	ath?
Records,	quire; n sign	q p	High	131	wood,	Pro	ssure					1 🗆 1	es 2	□No 3□	Probabl	y 4 Un	known
00	s bee	olete	. ,		,							24a. Was		24b. Were	autopsy	findings av	/ailable
	The law te has age 2	Completed						-					rmed?	death	to compl ? 'es 2F	etion of cau	ise of
Vital	en: rtifica tor, p	0	25. Was case referred to medi	cal						26. Place	of Death	1 ☐ Yes (Check only o	X	101			
	Phyaiclen: r this certific ral director,	To B	examiner? 1 ☑ Yes 2 ☐ No		Hospital: 1 🗆	Inpatient	2 ER/Outpati	ent 3 DC	Oth e	er: 4 ☐ Nu	rsing Hor	ne 5 K∏ Resid	dence	6 ☐Other (S	pecify)		
n of	ng Pl		27. Manner of Death 1 ☑ Natural 5 ☐ Pen	dina	28a. Date (Mor	of Injury th, Day Ye	28b. Time Injury	of 2	28c. Injury Work	at k?	12	28d. Describe h	now injui	y occurred			
Sio	Attanding r death. actor: After	catl		stigation				М	10'	Yes 2 ☐!							
Division	or At fter d Siract in by	Certification:		rmined	28e. Placi	of Injury - ing, etc. (S	At home, farm, : Specify)	treet, factor	y, office		1	28f. Location (S City or Tox			Rural Ro	oute Numbe	9Γ,
	Hospital or 24 hours afte Funaral Dir tely filled in		29a, Certifier 1 ☑ Certif	ring Phy	reicien: To th	n hoet of m	v la sudadas da	24b 222	at the time		d alasa d						
	To the Hospital or Attanding Phyalclen: The I within 24 hours after death. To the Funaral Diractor: After this certificate ha completely filled in by the funeral director, page	edical	(Check only 2 Medic	al Exam	iner: On the b	asis of exa ner stated	y knowledge, de amination and/or	investigation	, in my op	ne, date and pinion, deal	n place, a th occurre	and due to the o	date and	and manner place, and d	as state	d. e cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certi	Her _	. 0	1		29	c. License	number			29d. Da	e signed (Mo	onth, Day	r, Year)	
}	- s + ō		> M.C	17	/acs	kge I	du de		00	033	291	6	11.161	20 200	الا		
	h		30. Name and address of pers	on who c	ompleted cau	se of death	(Item 23a) (Typ				•		JUNE	28, 200	J4		
	<i></i>		NEIL PADGET						GLEN	BURNI	E, MD	21061					
	Sta Registr		31. Date filed (Month, Day, Yea	104	32. F	Registrar's	Signature	lone	10								

				State of Maryland / Department of Health and Maryland / Department of Health and Maryland / Department of Department of Health and Maryland / Department of Health And Maryland / Department of Health And Maryland / Department	, ,	2001 0	0161
7 mag.				1. Decedent's Name (First, Middle, Last)	2. Date of Death	g. No. U U 4	Time of Death
		Physici		Jack Francis Bocher	Month	Day Year	
7.000		/Medi Examir	-	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	June 26	4c. County of Death	:45 A ^M
	1	Examin	iei	Gilchrist Center Baltimore			
		Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Baltimore 9. Birthplace	(State or Foreign
		Director		135-05-4367 104 M 2 F 90 Yrs. Months Days Hours Min.	May 2,	rear) (Country)	
		pe ,		Usual Residence of Decedent		1211	<u> </u>
		anylai shov	_	10a. State 10b. County 10c. City, Town or Location			nside City Limits
		r 28a-f show	Director	Maryland Baltimore Hunt Valley			☐Yes 2 💢 No
		with th	洁	10e. Street and Number 10f. Zip Code	109	g. Citizen of What Country?	
		s 23e or	ıral	400 Symphony Circle #068 21030		U.S.A.	
0		ltem Item	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 12 □ Married 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - American In Black, White, etc.	idian,
A.	336	urs aft	by F	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No Specify: 3 ☒ Widowed 4 □ Divorced 1 □ Yes 2 ☒ No Specify:		Specify:	
5	215-0036	filed within 72 hours after death with the Maryland Hygiene. uther then "naturel", or Items 23e or 28a-f show ent, I to Martical Examinar must be molified at	ted	15. Decedent's Education 16a, Decedent's Usual Occupation	16	White 6b. Kind of Business/Industr	
4.48	215	hin 7	Completed	(Specify only highest grade completed) [Give kind of work done during most of work life. DO NOT use retired] [Give kind of work done during most of work life. DO NOT use retired]	rina	altimore City	,
2	21	e filed within Hygiene.	Son	4 Chief of Transportation		Schools	
01	p	i be filed ntal Hyg ed other	Be (17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle, Ma	aiden Sumame)	
	yla	Ment Ment arkec	To	Van H. Hull Bessie		twright	
7	Maryland	2 should be f and Mental P is marked of reumetic eve		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run	ral Route Number, (City or Town, State, Zip Code	9) 21030
)		2 = C				t Valley, Mary	
9	ore	Pages 1 all nent of Heal net: If item int: If item iny or othe		1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State	Date 20	Oc. Location - City or Town, S	State
7	Baltimore,	E @ 3	1	'4 Donation 5 Other (Specify) Hilltop Service Corp 6-28	-2004 T	Towson Mary	/land
à	Bal	permit Depart Import any in		21. Sonature of Funeral Service Licensee 22. Name and Address of Facility	ck Towsor	n Funeral Home	e, Inc.
9		0.0340	-	1050 York Road T	owson, Ma	eryland 21204	+
8				23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.		Inter	roximate rval Between et and Døath
		Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Metastatic Cung Cauc	eR	ne	nth
6	4	Examiner		Due to (or as a consequence of):			
X			-	Sequentially list conditions, it any, leading to immediate but to (or as a consequence of):			
N	V	nsit	Examiner	cause. Enter Underlying Cause (Disease or injury			
5	,	be executed iician and burial-transit	Exal	that initiated events c. resulting in death) Last Due to (or as a consequence of):			
19	8760	Physicien: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	dicai	d			
M	89	tificate ig phys as the	led				
S	ŏ	aath certific attending p for use as	M/N	IF FEMALE: 23b. Was decedent pregnant in the cost 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of delivery	
4	. B	ne death the atte hed for	by Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		Month Day	Year
2	P.0	that the d ed by the detached	Phy	9 Li Unknown		1	
Q	Ś	ires tha signed I be del	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		cco use contribute to the cau	
	Division of Vital Records,	v requires been sign should be	Completed		1 🗌 Yes	2 No 3 Probably	4 □Unknown
	ec	e law has b je 2 sł	nple		24a. Was an autopsy	24b. Were autopsy fir prior to completion	ndings available on of cause of
	E H	: The I	Cor		performe	d? death? No 1 ☐ Yes 2 ☐ N	No
	Vita	ysicien: This contificate director, pag	Be	examiner:	h (Check only one)	17	,
	of	Phys this al dir	<u>ا</u>	1 Inpatient 2 EH/Outpatient 3 DOA 4 Nursing Ho	me 5 Residence		ospice
	-CO	ling After fune	tion	1 Natural 5 ☐ Pending (Month, Day Year) Injury Work?	28d. Describe how	injury occurred	,
	İSİ	Attendi death. ctor: A y the fu	fica	3 Suicide 6 Could not be	28f. Location (Stree	et and Number or Rural Rout	te Number
	Ö	after after Dire	Certification:	4 ☐ Homicide building, etc. (Specify)	City or Town, S	State)	io rvambor,
		spita nours nerel		29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,	and due to the caus	se(s) and manner as stated.	
		To the Hospital or Attene within 24 hours after death To the Funerel Director: completely filled in by the	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation in my opinion, death occurr	ed at the time date	and place, and due to the e	ause(s)
		To the withing To the complex	ž	29b. Signature and title of certifier 29c. License number	29d.	. Date signed (Month, Day, Y	(ear)
)			M Anthony Mily us D25205	Jo	ne 26,200	94
		12+1		30. Name and address of person who completed a se of death (Item 23a) (Type, Print)	2.00	1 / 5	
		10111		W. H. Kiley GBM (6701 M. Charles St. F.	Talto. N	11 21204	
	:	Sta Registr		29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29c. License nu			

JOSEPH E. BLAIR 04-04145 RKD

_			For State Registrer	State of Ma					ealth a	nd Me		gien Reg. N	200) l ₄	2016	5.2	
-	Physic	an	1. Decedent's Name (First, Middle, Las	,				·		2	2. Date of De Month	ath Da	iy	Year	3. Time of D	eath	
	/Medi	cal	Joseph E. Blair 4a. Facility Name (If not institution, give	III			4h Cin. 3	T	Landing of		JUNE		20		2:30P.	М	
	Exami	ıer	22	APT.2512					Location of	Death			. County				
	Funeral		5. Social Security Number 6. Se		(In yrs. last birth		If Under Months	1 Year	If Under 24		B. Date of Bird		BALTI	9. Birth	place (State or F	Foreign	
	Director		210 04 0047	M 2□F	50 Y	rs.	MOTITIS	Days	Hours	Min. 0	Month, Da	y, Year, 19.	53	Virg	ginia		
	aryland show		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Loca	ation		·					1.	10d. Inside City	Limite	
	the Maryla 28a-f shor	tor	MD Baltimore		Towson										1 🗆 Yes 2		
	ith the or 28a	Director	10e. Street and Number				10f. Zip	Code				10g. Ci	tizen of V	Vhat Cou	ntry?		
	leath wi		28 Allegheny Ave				212	204			Į	JSA					
	after dea or Items ring m	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces?	ver in U.S.	13. W	as Decede Yes, speci	ent of His ify Cubar	spanic Origin n, Mexican, I	n? (Speci Puerto Ri	fy Yes or No can, etc.)	-		e - Americ k, White,	can Indian, etc.		
920		by	3 Widowed 4 XDivorced	1 ☐ Yes 2X No If Yes, Give Year or Dates:	9	1[□Yes 2	No 💢	Specify:				Specify	:	vhite		
5-0	72 hours "neturel",	Completed	15. Decedent's Edi (Specify only highest grad		16a. D	ecede	nt's Usual	Occupa	tion	of working		16b. K	ind of Bu				
121	vithin ne. han "	mple	Elementary/Secondary (0-12)	College (1-4or 5+	-)				uring most o	si working							
5	Hygie ther t		17. Father's Name (First, Middle, Last)	3	Uwn	er/	Manag	1	10 Mathada	a Nama //	Cimb Middle		ing		any		
an	ld be ental ked o	To Be	Joseph E. Blair, J	r							First, Middle, Stine			,			
Maryland 21215-0036	12 should be filed within 7 h and Mental Hygiene. 7 Is marked other than "Reumatic event, Ita Med	F	19a. Informant's Name/Relationship (T)		19b. N	Mailing	Address				Route Numbe			State. Zin	ste Zin Code)		
	and 2 salth a n 27 ls		Joseph E. Blair, J	r. / fathe							rstowr				,		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "netur eny injury or other traumatic event, Ital Medical once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	20b. Place of D cemetery,	Dienneit	tion /Mam	a of		Date					wn, State		
ţi	tment tant: tant:		'4 ☐ Donation 5 ☐ Other (Specify)		St. Alpho					/28/0	4	Woo	dsto	ck, I	MD		
Bal	permit. Page Department of Important: If eny injury of		21. Signature of Funeral Service Licens)					of Facility	,					Road		
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	ications that caused t	he death Do no				1 Fune			T	OWSO	n, M	Approximate		
Ш	Physician /Medical Examiner private properties of the properties of the properties of the physician properties of	Examiner	d any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of)):	CAR	וסומ	PE W	IAR	920	AS C	Ms.		Interval Betwee Onset and Dea		
P.O. Box 68760,	t the death certificate by the attending phys ached for use as the	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	d. 3c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti	Fetal death	3 □E	ctopic pred					2	23d. Date Mont		ry Day Year	r	
	w requires that been signed should be det	by	Part II. Other significant conditions con	tributing to death but	not resulting in th	ne unde	erlying cau	use giver	in Part I.			bacco u es 2[_		e cause of death	- 1	
	The ate h page	Completed									24a. Was a autops perform	SΥ	de	ior to con ath?	esy findings avai apletion of cause 2 - No	iable e of	
Vital	Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 □XYes 2 □ No	ospital:				Other			check only on						
of		-	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day)	2 ER/Outpa 28b. Tim (ear) Inju	e of	3□ DOA 280 M	c. Injury a Work?	4 LI Nursir	28d	5 🗌 Reside				SCENE		
Division		Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	/ - At home, farm (Specify)	, street	, factory,	office		28f.	Location (St City or Town	reet and n, State)	Number	or Rural	Route Number,		
	To the Hospitel or / within 24 hours after To the Funeral Dire completely filled in b	Medical	one)	sicien: To the best of ner: On the basis of ea and manner state	xamination and/o	leath or	itigation, ir	n my opir	non, death o	lace, and occurred a	due to the ca at the time, da	ause(s) ate and	and mani place, an	ner as sta	ited. the cause(s)		
	To Mit	Σ	29b. Signature and title of certifier				29c. L	_icense r	number		2	9d. Date	signed (Month, D	lay, Year)		
			- unesc					0.C.	M.E.		J	UNE	25,2	004			
	5			510, MD				nn S	treet	, Bal	ltimor	e, M	[arv]	and	21201		
Ser Lu	Sta Registra	e ir	JUN 2 8 2004	32. Registrar's	s signame	400	outs						-	,555			

			For State Registrar			State	of Ma	arylan	-	artment of F		Mental H	lygie Reg.	200		20163
	Physici	an	Decedent's Name		e, Last)					Dreary		2. Date of Month		Day	Year	3. Time of Death
	/Media	al	Donna 4a. Facility Name (In		n aive stre		Mari			Brown 4b. City. Town, or	r Location of Death	6	23	2004 4c. County		7:55p M
	Examir ————	er	Joseph 5. Social Security N	Richy					lane himbulani		altimore If Under 24 Hrs.		2:	NA		
	Funeral Director		214-86-6]			2[X F	7. Ag	37	last birthday) Yrs.	Months Days	Hours Min.	8. Date of 1	$\prod_{i=1}^{Birth} Y_i$	²⁶ 7	9. Birthp Coun	lace (State or Foreign try) Md.
	pu »		Usual Residence of 10a. State					10- 0	T1		1					
	death with the Maryland ms 23a or 28a-f show Linus! be notified at	ō	Md.	10b. County	NA			TOC. CIT	y, Town or Lo Baltim						1	0d. Inside City Limits Y☐ Yes 2 ☐ No
	r 28a-	Director	10e. Street and Nur	mber						10f. Zip Code			10g.	Citizen of V	Vhat Coun	
	th with	al D	1700 N.	Gay St	reet	Αŗ	ot.]	L28 F	`	21213				USA		
	ar dea tams	Funeral	11. Marital Status		12.	Was Dec Armed F 1 ☐ Yes	cedent orces?	Ever in U	.S. 13. \	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (San, Mexican, Puert	pecify Yes or I	No-		Ameno k, White,	an Indian, etc.
36	rs afte	by Ft	1 X Never Marri 3 ☐ Widowed			1 ☐ Yes If Yes, G Year or [ive	No		I□Yes 2X No				Specify		ack
9-0-	2 hou	ted !		15. Deceder	t's Educat	tion			16a. Deced	lent's Usual Occup	ation		166	. Kind of Bu		
218	within 7 ene. than "n	Completed	Elementary/Secon		st grade c	College (5+)		kind of work done of OO NOT use retired		king				•
121	iled w Hygier ther th		9th grac		l ast)				Hou	sekeeping	18. Mother's Nam	on /First Midd		Windon		5T
/ Maryland 21215-0036	uld be i Mental I irked o	To Be	Theodore		Luon			Bro	wn		Bever	_ '	no, man	Pear		
Mary	2 sho and I Is me		19a. Informant's Na			-				g Address (Street a						
	1 and Health am 27 thar ti		Beverly I		5	Mo	othe			N. Gay S	St. Apt.	128, B				21213
/33/01 Baltimore,	Pages nent of I int: If its iry or o		1 ♣ Burial 2 [`4 □ Donation	Cremation		noval from	State	c	emetery, cren	Mem. Gar		80-04		. Location - Dundal	-	
Balti	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic avent, I'm Medical Exercited in trust be notified at 90cs.		21. Signature of Fu	neral Service	Licensee	am	2			Name and Addres	•	Bal 1101 E		ore, M		21202
			23a. Part1. Enter the shock, or hear	ne disease, or nt failure. List	complicat	tions that	caused each lir	the deat	h. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory	arrest,			Approximate Interval Between
	Physician		Immediate Cause (Final n	_ a.	Ac	qu'iy	red 1	mmune	deficience	y syndra	ne				Onset and Death
	/Medical Examiner		resulting in death)			Due to	(er as	a conseq	uence of):		3					
		er	Sequentially list cor if any, leading to im cause. Enter Under Cause (Disease or	nditions, mediate	b	Due to	(or as	a consequ	uence of):							
W	cuted nd ransit	Examiner	that initiated events		S c											
50,	ate be executed hysician and the burial-transit		resulting in death) L	_ast		Due to	(or as	a consequ	uence of):							
75/	ate hys	dica			d											
₽ ŏ	certification of use as t	n/Me	IF FEMALE: 23b. Was decedent	pregnant	23c.	If yes, ou	tcome	of pregna						23d. Date	of delive	v
, B	death he atter	Physician/Medical	in the past 12 .	months?			nant at	2 Fetal		Ectopic pregnancy Other (specify)				Mon		Day Year
2.9.	ires that the death certific signed by the attending p d be detached for use as i		9 ☐ Unknown Part II. Other signifi	icant condition	ons contrib			ut not resi	ulting in the ur	iderivina cause give	an in Part I.	23e. Did	l tobacc	o use contri	bute to the	a cause of death?
20 c	w requires that the been signed by th should be detache	ed by										1] Yes	2 X No	3 🗌 Proba	bly 4 □Unknown
000	₹ 0 0	Completed										24a. Wa	s an opsy	pı	ior to con	sy findings available
<u></u>	Phyaiclan: The lavithis certificate has al director, page 2											per 1 🗆 Yes	formed 2 X	? de	eath?	2 X No
Z = = = = = = = = = = = = = = = = = = =	Phyaiclan: this certific	o Be	25. Was case referr examiner?		Hos	pital:	Inpatie		ED/O	Othe	26. Place of Deat			·		d.
101	g Phy er this eral d	-	27. Manner of Death	ì	1	28a. Date (Mon			28b. Time of	28c. Injury Work	4 Linuising no	28d. Describe				Hospice
Sign	Attanding r death. actor: After	atio	1 Natural 2 Accident	5 Pendir investi	gation	(101011)	iiii, Daj	r reary	Injury		res 2 🗆 No					
On na Division	after de Diracte d in by t	Certification:	3 Suicide 4 Homicide	6 Could determ		28e. Place build	e of Inju ling, etc	ury - At ho c. (Specify	ome, farm, stre	et, factory, office		28f. Location City or To	(Street own, St	and Numbe ate)	r or Rural	Route Number,
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	Sta Registr	_	31. Date filed (Mont				Registra	ar's Signa		bouls						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Manyland Department of Health and Mental Hygiene Reg. Ng. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Stella C. Bouse 17, 10:15P M June 2004 /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death Examiner Carroll County Hospital Carrol1 Westminister If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 □ M 2X F Yrs 88 12/15/1915 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 □ Yes 2□No Be Completed by Funeral Director Carrol1 Hampstead 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1860 Aqua View Drive 21074 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 IX No Specify: White 3 XWidowed 4 ☐ Divorced 'neturel', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any jury or other traumatic svent sons: John Zamenski Stella Gegorek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John H. Bouse III/Son 12007 Caspian Road Kingsville, Maryland 21087 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/23/04 Holy Redeemer *4 □ Donation 5 □ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Miller-Dippel Funeral Home Inc. 6415 Belair Road Baltimore, Maryland 21206 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shack, or heart lailure. List only one beuse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Theumonia 0ower Physician /Medical Due to (or as a consumuence of) Examiner 10 0 xema Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a sonsequence of) Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760. Be Completed by Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 Probably 4. Onknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed 2 No 1 Yes Division of Vital 25. Was case referred to 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ 10 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation 1 🖃 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Medical

within 24 hours a To the Funeral D

1 Lartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only onel and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed ause of death (Item 23a) (Type, Print) HOSP. CTR. WESTIMINITER IN MI CARROLL 31. Date liled (Month, Day, Year) 32. Registrar's Signature JUN 2 8 2004 **ORIGINAL**

State Registrar

		_	I- For AMEND ITEMS 4A, State of Maryland, Department of Health and M. Certificate of Death	ental Hygier Reg.	ne 2001	20165
	hysicia /Medic Examin	al er	1. Decedent's Name (First, Middle, Last) June Brockett 4a. Facility Name (If not institution, give street and number) 8837 YOUNGSEA PLACE Columbia of Death	June 3	Day Year 2004 4c. County of Deat	
	ineral rector		8832 Youngsea Place 5. Social Security Number 6. Sex 1 M 2 F 63 7. Age (In yrs. last birthday) 1 Months Days Hours Min. 1 Usual Residence of Decedent	8. Date of Birth (Month, Day, Ye June 13		hplace (State or Foreign untry) irginia
e Maryland	e-f show	ctor	10a. State 10b. County 10c. City, Town or Location MD Howard Columbia			10d. Inside City Limits 1 ☐ Yes 2 🙀 No
th with th	23e or 28e-f	rai Director	10e. Street and Number 10f. Zip Code 21045		Citizen of What Co	
within 72 hours after death with the Maryland ene.	item 27 is marked other then "naturel", or items 23e or 28e-f sho) other treumatic event, the Medical Exandrat must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Size Yes, Specify Cuban, Mexican, Puerto I I Yes, Sive Year or Dates: 13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I Yes, Sive Year or Dates:			_{e,etc.} rican rican
within 72 he	then "natu	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working) life. DO NOT use retired)	ng	. Kind of Business	Industry
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1 and 2 should Health and Men	tem 27 is ma other treuma		20a. Method of Disposition	e, Colu		d. 21045
dilinor	Importent: If its any injury or o		1 Burial 2 Cremation 3 Removal from State Columbia Mem. Park 6/05			
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/M	edical miner	_	Due to (or as a consequence of):	Сорс		y corks
be executed	ysician and ne burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of):			years
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.O. DOX 00 the death certifical	ned by the attendi s detached for use	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Fetal death 3 Ectopic pregnancy 1 Pregnant at time of death 5 Other (specify) 9 Unknown		23d. Date of de Month	livery Day Year
COLOS, P	s been signed t should be det	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Depress ion (yrs), obegity, recent bilateral femor fractures			o the cause of death? robably 4 □Unknown
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VICAL sicien: 1	this certificate ral director, pag	o Be (25. Was case referred to medical examinary 11/7 yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho	n (Check only one) me 5 Mesidenc	e 6 FlOther (Spe	cify)
UIVISION OF VITA To the Hospitel or Attending Physicien:	ffer	 -	27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 1 PM M 28c. Injury at Work? 1 PM M 1 Yes 2 PMo	28d. Describe how fell in for	injury occurred	
UIVISION itel or Attending	To the Funeral Director: A completely filled in by the fu	Certification;	4 ☐ Homicide determined building, etc. (Specify)	28f. Location (Stree City or Town, S	asin 10.	above
a Hosp	ne Fune pletely fi	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and place, constant of the place of the plac	ed at the time, date	and place, and due	e to the cause(s)
Totl	Totl	Ž	29b. Signature and tyle of certifier Deputy 29c. License number	,	Date signed (Moni	
27)		30. Name and address of pyrson who complete cause of death (Item 23a) (Type, Print) PATRYCE A. TOYE, MD 4565 Heinlock Cone Way Ell	ricall Gt	me 3, MO 21	042
:	Sta Regist	ate	PATRY CR A. TOYE, MD 4565 Hemlock Come Way Ell 31. Date filed (Month, Day, Year) JUN 2 8 2004 Security Signsture Aparls JUN 2 8 2004			

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	and *		Usual Residence of De	ocedent Ob. County		10c. City	, Town or Lo	cation							10	Od. Inside City Limits
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year Physician 10.50AM JANE CASON Z4 2004 /Medical Time 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner If Under 1 Year If Under 24 Hrs. NA LEUINDALE NURS. HOME 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 M 250F Yrs. Sep 26 1930 **Director** 212-26-1203 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 Is marked other then "natural", or Items 23e or 28e-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State itam 27 is marked other than "natural", or Itams 23s or 28s-1 show other traumatic evant, the Medical Examiner must be publical at 1 TXYes 2 □ No Director BELAIR MD HARFORD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21014 USA 1233 GRAFTON SHOP Rd Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: ARMY 1 Never Married 2 Married or i altimore, Maryland 21215-0036 1 ☐ Yes 2 ♠No Specify: WHITE þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOME HOME MAKTIL 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ္ပ MURPHY CECILA Mueller DANIEL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) i 233 6 p /se Town Sno, Rel ce of Disposition (Name of Date Belain Med CALVIN M. CHSON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
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any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/28/04 4 ☐ Donation 5 ☐ Other (Specify) GAODENS OF FAITH 22. Name and Address of Facility

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12. Na 21. Signature of Funeral Service Licensee 23a. P 1.1. Inter the discusse, or complications that cause in sinck, or heart failure. List only one cause on each line. the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Onset and Death Stage Disease **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed Freum 2 No 1 Yes or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No P After this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D56508 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) XIANG RONG SHADO Belvedere Beltim ine W 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 2 8 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 26, 2004 5:50 Mary DeFrances ам June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Dundalk Baltimore Heritage Nursing Center If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Oct. 12, 1916 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1 □ M 2 🛛 F 213 76 6639 87 Director Maryland Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Baltimore Essex Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 929 Back River Neck Rd. 21221 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 Yes 2√ No Specify: If Yes, Give Year or Dates: Specify: White 3 XWidowed 4 ☐ Divorced "netural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other treumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "ne eny Injury or other treumatic event Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Genevieve Landolfo Dominic Cantore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dolores Kelly (Daughter) 919 Essex Square Baltimore, Md. 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Most Holy Redeemer 6/30/2004 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 21. Signature of Funeral Service License 1407 Old Eastern Avenue Essex, Md. 21221 Parl . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shork, or heart failure. List only one cause on each line.

ediate Cause (Final ase or condition

ATHEROSCLEROTIC CARDIO VASCL. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed use as the burial-transit MENTIM the attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 XNo Year Month Day 5 Other (specify) 4☐Pregnant at time of death 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performe 2 No 1 Yes Hospital or Attending Physicien: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Cther: 4☑ Nursing Home 5☐ Residence 6☐Other (Specify) Certification: To 1 ☐ Yes 2 🔀 No 1 Inpatient 2 EP/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel L 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Registrar's Signature State Registrar

			See	State of Maryland	/ Depa	rtment of He	alth and N	lental Hygi	iene	
			1 - State Registrar		Cer	tificate of D	eath	Re	9.19.	20160
	Physicia	20	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Yeer	3. Time of Beath
	/Medic		Clayton Atwoo	d Dietrich		A Ob Town oil		June 25	4c. County of Death	4:30 A M
	Examin	er	4a. Fecility Name (If not institution, give s Brighton Gardens	treet and number)		4b. City, Town, or La Baltimon			Baltimo	
	Funeral		5. Social Security Number 6. Sex		t birthday)	If Under 1 Year	f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		place (State or Foreign ntry)
	Director		219-01-6136	M 2□ F 85	Yrs.	Monuis Days	Hours Will.	07/20/19	918 PA	
3	MC II		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	mary	ţō	MD Baltimor	e Tou	son					1 □Yes 2 🛣 No
4	or 28g	lrec	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cou	
1	23a	ral	204 E. Joppa Roac			21 28		-7 //	United St	
	itams	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S. Armed Forces? 1 XXYes 2 ☐ No ☐ ☐ ☐	T	Vas Decedent of Hisp Yes, specify Cuban,	Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - Amer Black, White	, etc.
3	ral', or	þ	3 ♥ Widowed 4 □ Divorced	If Yes, Give Year or Dates:	- '	☐ Yes 2X No	Specify:		Specify:	Uhite
	natu dical	Completed	15. Decedent's Edu (Specify only highest grade		16a. Deced	lent's Usual Occupati kind of work done dui OO NOT use retired)	on ring most of work	ring	16b. Kind of Business/li	ndustry
4	than	dmc	Elementary/Secondary (0-12)	College (1-4or 5+) 5 +		deral Law		1	riminal Ju	stice
3	Hygi other	0	17. Father's Name (First, Middle, Last)	J T				e (First, Middle, N		3 0 1 0 0
9	Venta Venta Irked	P P	Clayton Atwood Di	etrich, Sr.			Margaret	Cather	ine Haas	
ָם נ	permit. Pages 1 and 2 should be lied within 72 hours after useful with the maryland Department of Health and Mental Hygiene. Department: If them 27 is marked other than "natural", or itams 23a or 28a-f show eny injury or other traumatic event, the Medical Examinar must be notified at Once.		19a. Informant's Name/Relationship (Ty) Margaret Dietrich			g Address (Street an			City or Town, State, Zin, Marylan	_
֓֞֞֜֞֜֞֜֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֡֜֜֓֓֓֓֓֡֓֜֡֓֡֓֡֓֡֡֡֡֓֜֡֓֡֡֡֡֡֡	n and Health em 27 ther t		20a. Method of Disposition			sition (Name of natory or other place)			20c. Location - City or T	
5	ages ant of ht: If It y or o		1 ⊠ Burial 2 ☐ Cremation 3 ☐ R 14 ☐ Donation 5 ☐ Other (Specify)	emoval from State		ige Cemete	rv 06/3	30/2004	Pikesvill	
	partme Sortar		21. Signature of Funeral Service License			. Name and Address	7 m		n Funeral	
<u> </u>	Departiment of the control of the co		Myllo le			050 York	Road To	wson, Ma	ryland 21	204
			shock, or heart failure. List only or	cations that caused the death.						Approximate Interval Between Onset and Death
F	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	trobable	- 7	cute	1000	erdizil J	Infection - Disease	id hours
E	Examiner			Due to (or as a conseque	lero	tic Ca	sdior	ascular	- Disease	
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or es a conseque						
	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	nce of):					
8	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	ical E		540 to (or 45 a conseque	1100 01).					
00	micate g phys as the									
5	ending nuse a	an/M	23b. Was decedent pregnant	3c. If yes, outcome of pregnance 1 □ Live birth 2 □ Fetal d		Ectopic pregnancy			23d. Date of delin	
	ie dea the att	Physiclan/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at time of dea 9□Unknown	ith 5□	Other (specify)			Month	Day Year
	ed by detac		Part II. Other significant conditions cor	ntributing to death but not result	ing in the u	nderlying cause given	in Part I.	23e. Did tob	acco use contribute to	the cause of death?
<u>.</u>	n sign	d by	Gastropares	٤١,				1 □ Ye	s 2. No 3 □ Pro	bably 4 □Unknown
3	aw require is been si 2 should t	Completed	Dementia					24a. Was ar	24b. Were aut	opsy findings available ompletion of cause of
	ate ha	Com						perform	ned2 death?	2 🗆 No
10	ilcian: In certificate rector, pag	Be	25. Was case referred to medical examiner?	lospital:				h (Check only ope		
5 8	ding Physician: The law h. After this certificate has funeral director, page 2 :	. To	1 Tyes 2 PNo 27. Manner of Death	1 □ Inpatient 2 □ Ei	R/Outpatien 8b. Time of	t 3 DOA Oner: 28c. Injury a Work?	4 ☐ Nursing Ho	28d. Describe ho	nce 6 Other (Special of the following occurred)	fy)
	nding ath. r: Afte e func	atlor	1 ☑Natural 5 ☐ Pending investigation	(Month, Day Year)	Injury		s 2 🗆 No			
2 3	r Atte er de recto recto	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, str	eet, factory, office		28f. Location (Str. City or Town	eet and Number or Rui , State)	al Route Number,
ָׁ	ortal o		Con Continue 4 D Continue Phys	sision. To the best of a leaded	ladas dasth		data and place	and due to the en		and a d
	P Hosp 24 ho Fune etely f	edlcai		sician: To the best of my knowl ner: On the basis of examination and manner stated.						
1	To the Hospital or Attending Prwitin 24 hours after death. To the Funeral Director: After to completely filled in by the funeral	Me	29b. Signature and title of certifier	n. /		29c. License			d. Date signed (Month	
			Ville at	rulo ~	10,	1) 4	717	7	June 2:	, 2004
/	241		30. Name and address of person who co	empleted cause of death (Item 2		Print) 6301	N. CC	rarles	June 2: Balton	rave ho
_	Ctr	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signatu		2 Vat				

			1 - For State Registrer	State of Mar		artment o			lygiene Reg. Na		00170
	·		1. Decedent's Name (First, Middle, La	st)				2. Date of	Death	- U U 4	3. Time of Death
	Physic /Medi		MARIAN YOUN	IG DOOLAN				June	24,	y Yea	1:45 p M
	Exami		4a. Facility Name (If not institution, give	street and number)		4b. City, Tow	vn, or Location	of Death	4c	. County of D	eath
			6707 Orem Drive		,	Laur				Prince	George's
	Funeral Director		5. Social Security Number 6. S 215-26-0731		'In yrs. last birthday) 79 Yrs.	If Under 1 You Months Da	ear If Under ays Hours	Min. (Month,	Day, Year)		Birthplace (State or Foreign Country)
			Usual Residence of Decedent	7121 /				Nov.	11, 13	924 Ma	aryland
	show	_	10a. State 10b. County	1	0c. City, Town or Lo	ocation					10d. Inside City Limits
	Ba-f s	cto	MD Prince	George's	Laurel						1 ☐ Yes 2 ☐ No
	vith th	Dire	10e. Street and Number			10f. Zip Cod	de		10g. Cit	izen of What	Country?
	s 23g	rai	6707 Orem Drive	40.144. 8			707			S.A.	
40	ter de	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Eve Armed Forces? 1 Yes 2 No				igin? (Specify Yes or n, Puerto Rican, etc.)	No-	14. Race - A Black, W	mencan Indian, hite, etc.
036	be filed within 72 hours after death with the Maryland hat Hygiene. od other than "natural", or Itams 23a or 28a-f show avant, the Medical Evant are must be inclined at	þ	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1□ Yes 2	No Specify:			Specify:	White
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Maryland 21215-0036	2 should be filed within and Mental Hygiene. is marked othar than aumatic avant, the M	Be c	Earl David Young					er's Name <i>(First, Mid</i> ian Lemmor		Sumame)	
ary.	should and Men s marke umatic	으	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	na Address (Str		er or Rural Route Nu		r Town State	Zin Codel
	# 52 m		Judith Doolan Row	les/Daughte		7 Chelr					land 20853
J'e,	ages 1 ar of Hea or othan		20a. Method of Disposition		20b. Place of Dispo		f	Date			or Town, State
Ë	Pages ment of ant: If its ury or o		1XXBurial 2 □ Cremation 3 □ `4 □ Donation 5 □ Other (Specify	r) Hemoval from State	Gate of H	-		6/29/2004	Sil	ver Sr	oring, MD
Baltimore,	permit. Pag Department Important: I any injury o once.		21. Signature of Funeral Service Licen	see/ M007	70 3	Name and Adonalds of 13 Talk	dress of Facilit	ral Home, enue Laur	P.A.		
	-		23a. Part1. Enter the disease, o comp shock, or heart failure. List only	plications that caused the						ar y ran	Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to (or as a co							
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9	death certificate be executed e attending physician and of for use as the burial-transit	0 1	IF FEMALE:								
Вох	eath certific attending p	ian/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐		Ectopic pregna	incy		2	3d. Date of d	
0	he de the a	Physici	1 ☐ Yes 2 🖾 🕷o 9 ☐ Unknown	4□Pregnant at time 9□Unknown	e of death 5	Other (specify,)			Month	Day Year
<u>a</u>	that the dense that the desirement of the desire	Ph	Part II. Other significant conditions co	ontributing to death but n	ot resulting in the ur	iderlying cause	given in Part I	23e Di	d tobacco us	se contribute	to the cause of death?
Records,	w requires that the been signed by the should be detache	ted by	Coronary Artery D								Probably 4 Unknown
Sec	as S	Completed	Carotid Disease						topsy	prior to	autopsy findings available completion of cause of
	Th ate pag		Aortic Aneurysm					pe 1 ☐ Yes	formed? 2XXIo	death?	
Vital		o Be	25. Was case referred to medical examiner?	Hospital:				of Death (Check onli			
of		\vdash	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	2 ER/Outpatient	3 □ DOA 1	nurv at	rsing Home 5 XXX			ecify)
ion	Attanding I r death. ector: After by the funer	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Ye	ear) Injury		njury at Vork? □Yes 2□N				
Division	r Attanger deatherder:	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S	- At home, farm, stre	et, factory, office	се	28f. Location	(Street and	Number or F	Rural Route Number,
	sprtal or ours afte naral Dir filled in	Cer	_								
	To the Hospital or Attandin within 24 hours after death. To tha Funaral Director: Aft completely filled in by the fun	Medical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	vsician: To the best of m iner: On the basis of exa and manner stated.	amination and/or inv	occurred at the estigation, in m	time, date and y opinion, deat	d place, and due to the h occurred at the time	e cause(s) a	and manner a place, and du	as stated. e to the cause(s)
	To t com	Σ	29b. Signature and title of certifier	1.0		29c. Lice	ense number		29d. Date	signed (Mon	oth, Day, Year)
}	*		1 Ladur	MD		D	22755		Jur	ne 25,	2004
	20		30. Name and address of person who c								
	-51		Christine DeLima, 31. Date filed (Month, Day, Year)	M.D. 7350	Van Dusei	n Road	#260	Laurel, Ma	arylar	nd 207	707
	Sta Registr	re l	JUN 2 8 2004	Bil.	A hoes	20					

ORIGINAL

	1 _ State		ment of Health and Me			
	Registrar 1. Decedent's Name (First, Middle, Last)			Reg. 2. Date of Death	 	3. Time of Death-
*Physician /Medical	Margaret P. Daug	gherty		Some 2	Day Year S 2004	10.34
Examiner	4a. Facility Name (If not institution, give street and number)	2000	b. City, Town, or Location of Death		4c. County of Death	
Funeral		- (j	f Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	9. Birthpl	ace (State or Foreign
Director	191-24-3634	93 Yrs. M		Aug 30,1		sylvania
yland	10a. State 10b. County	10c. City, Town or Locati			10	Od. Inside City Limits
Re-f s	Maryland Carroll		Hampstead			1 ☐ Yes 2x No
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23s or 28e-f show any injury or other treumetic event, it a Medical Eraminative notifications. To Be Completed by Funeral Director	10e. Street and Number 693 Boxwood Drive		10f. Zip Code 21074	10g.	Citizen of What Count USA	try?
r death	11. Marital Status 12. Was Decedent E Armed Forces?	Ever in U.S. 13. Was	s Decedent of Hispanic Origin? (Speces, specify Cuban, Mexican, Puerto R	effy Yes or No-	14. Race - America Black, White, e	
036 urs afte	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ N 1 ☐ Yes, Give Year or Dates:	1 □	Yes 2√√ No Specify:	,,		white
5-00	15. Decedent's Education (Specify only highest grade completed)		's Usual Occupation of work done during most of working	16b	. Kind of Business/Ind	ustry
21215-00 ed within 72 hou ygiene. The Madical for the mature of the Madical for the Madical fo	Elementary/Secondary (0-12) College (1-4or 5	ife. DO	NOT use retired) Secretary		Manufactu	ring
ind 2 be filed tal Hygin tal Hygin event, u	17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maid	den Sumame)	
ylar ylar bould bo Menta arked ettic en	Michael Plattner		Anna I			
Maryland 21215-0036 d2 should be filed within 72 hours att the and Mental Hygiene. 77 is marked other then "naturel; or treumetic event, its Madical Event To Be Completed by F	19a. Informant's Name/Relationship (Type, Print) Audrey Moose, daughter		ddress (Street and Number or Rural			
or Heal	20a. Method of Disposition	20b. Place of Dispositio	Pleasant Grove Rd		Stown, MD Location - City or Tow	
Baltimore, semil. Pages 1 ar Department of Hea mportent: If item in y injury or other ince.	1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify)	Castlevie	ew Cemetery 06/30/	/2004	New Cast]	le, PA
Ball permit Depar Impor any in	21. Signature of Fineral Service Licensee	WE J	ame and Address of Facility 34 South Main St,	Eline Fur	neral Home	7.6
	23a. Part1. Eater the disease, or complications that caused shock, or heart failure. List only one cause on each lin	the death. Do not enter th	ne mode of dying, such as cardiac or	respiratory arrest,		Approximate Interval Between
Physician	Immediate Cause (Final disease or condition		Ferebra			Onset and Death
/Medical Examiner	Due to (or as a	a consequence of):	ferchis	0 -		
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8760, cate be executed physician and the burial-transit dical Examír	d.	2 3 5 1 3 5 4 5 6 1 7 5				
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Box 6 Box 6 Beath certific leath certific attending p I for use as	23b. Was decedent pregnant in the past 12 months?	2 ☐ Fetal death 3 ☐ Ect	opic pregnancy ner (specify)		23d. Date of delivery Month	V Day Year
by the tachec	1 Yes 2 No 4 Pregnant at 1 9 Unknown 9 Unknown	time of death 5 D O(r	ner (specify)			•
ds, F lires tha signed d be del	Part II. Other significant conditions contributing to death bu		lying cause given in Part I.		o use contribute to the	
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Rec The lay te has age 2				24a. Was an autopsy performed?	death?	sy findings available oletion of cause of
	25. Was case referred to medical examiner?		26. Place of Death (1 Yes 2 1	1	∐ No
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vision-6 Attending Ph rdeath rdeath setor: After th oy the funeral	1º Natural 5 □ Pending (Month, Day	Year) Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	d. Describe how in	jury occurred	
Division- tel or Attending P rs after death. el Director: After ed in by the funers Certification;	3 ☐ Suicide 6 ☐ Could not be	ry - At home, farm, street, i	factory, office 28f	Location (Street a City or Town, Sta	and Number or Rural F ate)	Route Number,
Spitel of nours af nours af nours af all Cel	29a. Certifier 1—Certifying Physician: To the hest of	i mu knowlodno dosth one	usumand at the time of the send of			
24 h	(Check only 2 Medical Examiner: On the basis of one)	examination and/or investig	gation, in my opinion, death occurred	at the time, date a	nd place, and due to the	ne cause(s)
To the within To the comp	29b. Signature and title of certifier		29c. License number	29d. D	ate signed (Month, Da	ay, Year)
	20 Name and address of parent who are all the same in	noth (from CO-) (T	136-5848598	Ju	16 75,7	0.9
2	St. Agal Hospital, 960 Co	am (Item 23a) (Type, Print	Ballmore and	21229	1	
State Registrar	29b. Signature and little of certifier 30. Name and address of person who completed cause of deals of the completed cause of deals of the completed cause of deals of the completed cause of deals of the complete cause of the complete cause of the cause of	r's Signature	,			
DHMH 17 Rev 1/2001	JUN 2 8 2004	S. Marie				

			1 - For State Registrar	State of N	Maryland		artmen <i>rtificat</i>				ental Hy	giene Reg. Na			20172
	Physici /Medio		1. Decedent's Name (First, Middle, La Frances C.	Deters							2. Date of De Month June 26	Da		ar	3. Fine of Death 12:55 a ^M
	Examir		4a. Facility Name (If not institution, gives Stella Maris Hospice					moniu	Location of		8. Date of Bi		Baltimo	re	(0)
	Funeral Director		5. Social Security Number 6. S 220-12-4603 Usual Residence of Decedent	M 2DF	Age (In yrs. Ia	30 Yrs.	Months	Days	Hours	Min.	March 23	ay, Year,		ryla	
	Maryland of show	tor	10a. State 10b. County MD Baltimo	ore	1	, Town or Lo Baltimor			_					10	d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the	Director	10e. Street and Number				10f. Zip		^*			10g. Ci	tizen of What	Count	ry?
980	be filed within 72 hours after death with the Maryland stal Hygiene. ed other than "natural", or Itams 23a or 28e-f show event, the Madical Examinar must be notified at	by Funeral	15 Medici Court 11. Marital Status 1 Never Married 2 Married Widowed 4 Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	s? 【No		Was Deced I Yes, spec I ☐ Yes	cify Cubar	panic Ori	gin? (Spe i, Puerto I	ocify Yes or No Rican, etc.))-	USA 14. Race - A Black, W Specify: W	/hite, e	tc.
Maryland 21215-0036	e filed within 72 ho al Hygiene. I other than "naturi vent, the Madical	Completed	15. Decedent's E (Specify only highest gn Elementary/Secondary (0-12)		or 5+)	life.	tent's Usua kind of wo DO NOT us retary	rk done di se retired)	uring most	t of workir	ng		Cind of Busine		
/land	should be filed nd Mental Hygia marked other imatic event, L	To Be C	17. Father's Name (First, Middle, Last	DeDominicis					_	er's Name Ma	(First, Middle		Sumame)		
Mary	d 2 sh th and th and 7 is m treum		19a. Informant's Name/Relationship (Barbara Rinaudo-daug			19b. Mailir 2 Perh	-				Route Numb	_	or Town, State	в, <i>Zip (</i>	Code)
Baltimore,	permit. Pages 1 and 2 Department of Health Importent: If item 27 i any injury or other tre		20a. Method of Disposition 1	Removal from Sta	. Ce	ace of Dispo emetery, crer aney Va	sition (Nar	ne of)		ate	20c. L	ocation - City nonium, I		m, State
Balti	permit. Departm Importe any inju		21. Signature of Funeral Service Lice	nsee William	n G. Dau		. Name an			LC	onard J. more, MD			Fune	ral Home
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a. LARYNG Due to (or	EAL CA	RCINON lence of):		e of dying	, such as	cardiac o	r respiratory a	rrest,		1	Approximate Interval Between Onset and Death
8760,	icate be executed physician and s the burial-transit	dical Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequ	,									
.O. Box 6	requires that the death certificate be executed een signed by the attending physician and hould be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🛣 No 9 ☐ Unknown		2 ☐ Fetal at time of de	death 3	Ectopic pr Other (sp						23d. Date of Month		y Day Year
rds, P	w requires that been signed t should be det	by	Part II. Other significent conditions	contributing to death	n but not resu	Iting in the u	nderlying c	ause give	n in Part I.			obacco Yes 2			cause of death?
Il Records,	The law ate has b page 2 s	Completed							24a. Was auto perfo 1 🗆 Yes		prior t death	to comp	sy findings available pletion of cause of		
Vital	Physicien: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼ No	Hospital: 1 ☐ Inpa	atient 2 🗆 8	ER/Outpatien	t 3 DC)A Othe	-	-	(Check only one 5 ☐ Resi		6 X Other (S	pecify)	HOSPICE
ion of	ling After fune	atlon; T	27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation	28b. Time of Injury	M 2	8c. Injury Work 1 🗆 Y	at	2	8d. Describe			··			
Division	i Diffe	Certification;	3 Suicide 6 Could not be determined	286. Place of	Injury - At hor etc. (Specify	me, farm, str	n, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	e Hospitel 24 hours a e Funerel I etely filled	edical	29a. Certifier (Check only one) Certifying Plant Certifying Certifying Plant Certifying Plant Certifying Plant Certifying Plant Certifying Plant Certifying Plant Certifying Plant Certifying	nysicien: To the be miner: On the basis and manner	of examinati	wledge, death ion and/or in	occurred vestigation	at the time in my op	e, date an inion, dea	d place, a th occurre	and due to the ed at the time,	cause(s date and) and manner d place, and d	as stat lue to ti	ted. he cause(s)
)	To the within 2 To the complet	Me	29b. Signature and title of certifier			290	License	number 2	25		29d. Da	29d. Date signed (<i>Month, Day, Year</i>)			
	5		30. Name and address of person who DR. TARIQ MAHMO		of death (Item			RD.	TIMO	NIUM -	MD 21	093			
	. Sta		31. Date filed (Month, Day, Year) JUN 2 8 2004		strar's Signat		lon	1/2/					=		

DHMH 17 Rev 1/2001

FRANCES DETERS

			Please	Type or Print	in Black Ir	ndelible Ink	. Ensure Al	l Copies A	re Legible.	
			1 - For State Registrar		yland / Dep		Health and M	lental Hygie		20171
	Physic	on	1. Decedent's Name (First, Middle, La	ist)				2. Date of Death Month		3. Time of Death
	Physic /Medi		Clara C. Ferret					June 26, 2		12:42AM M
7	Exami	ner	4a. Facility Name (If not institution, given Stella Maris Hospic				or Location of Death		4c. County of De	
	Funeral		Stella Maris Hospic 5. Social Security Number 6. S		In yrs. last birthday	Timoniu	If Under 24 Hrs	8. Date of Birth	Baltimor	thplace (State or Foreign
	Director			1□M 2□F	78 Yrs.	Months Days	Hours Min.	0ct. 29,19	25 Mar	runtry) by land
	larylan show		10a. State 10b. County	1	0c. City, Town or L	ocation				10d. Inside City Limits
	he Ma 8a-f	ecto	MD N/A		Baltimore	7				1 Yes 2 □ No
	ath with the s 23a or 2	Funeral Director	4100 Ardley Avenue			10f. Zip Code 21213	3	10g	U.S.A.	country?
936	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked othar than "natural", or items 23a or 28a-f show or other traumetic avent, the Medical Examination in the invittled at	by Fune	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of HIF Yes, specify Cub	Hispanic Origin? (Spe an, Mexican, Puerto I Specify:	city Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify: W	ite, etc.
5	72 hou nature	ted	15. Decedent's Ec (Specify only highest gra	ducation	16a. Dece	dent's Usual Occup	pation	16	b. Kind of Business	s/Industry
21215-0036	ed within ? giene. ar than "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	nemaker memaker	during most of workir d)	ng	Own Home	·
Maryland	12 should be filed within h and Mental Hygiene. 7 is markad othar than " fraumatic avent, the Mes	To Be (17. Father's Name <i>(First, Middle, Last)</i> Nunziato Rizzi)			18. Mother's Name Anna L	(First, Middle, Ma. aFortezza	iden Sumame)	
lary	2 should have and have managed and and and and and and and and and an	1 3	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street	and Number or Rura	l Route Number, C	ity or Town, State,	Zip Code)
	of Health itam 27 i			Son		Gee Court	Arnold, Mary		2	
Baltimore,	Pages 1 nent of H int: If ita iry or ot		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State		matory or other plac	ce)		c. Location - City or	
Ë		1	 4 Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen 		Parkwood (6/29/1 ess of Facility Leo		altimore, M	aryland
ä	permit. Departr Importa any inji		1 leasting	Con	MIII -		rd Road Balt:			
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the one cause on each line.	e death. Do not en					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	BREAST	CANCER					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a c	onsequence of):					
ь	<u> </u>	-	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a co	onsequence of):					
	ocuted nd transit	amine	cause. Enter Underlying Cause (Disease or injury	240 10 101 43 4 6	onsequence on.					
ó	be execusician and burial-tra	Еха	that initiated events resulting in death) Last	C. Due to (or as a co	onsequence of):					
68760,	icate be physicia the bu	icai	(d						
.O. Box 68	The law requires that the death certificate be exe tte has been signed by the attending physician ar bage 2 should be detached for use as the burial-t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown]Fetal déath 3 [Ectopic pregnancy Other (specify)	,		23d. Date of de Month	ivery Day Year
ds, P	ires that signed b	by	Part II. Other significant conditions co	ontributing to death but n	ot resulting in the u	nderlying cause give	en in Part I.			the cause of death?
Ö	w require been si should b	etec						-		obably 4 X Unknown
Vital Records,	ne law has ge 2 s	Completed						24a. Was an autopsy performed	prior to	topsy findings available completion of cause of
		e Co	OF Was appropriated to modical					1 Yes 2 X		2□ No
	Phyaician: this certific ral director.	0 B	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	2 ER/Outpatien	t all pos Othe	er:			
		-	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injun	4 U Nursing Hom	e 5 Hesidence 3d. Describe how in		HOSPICE
io	Attanding F r daath. actor: After by the funar	atio	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	1	ear) Injury		K? Yes 2 □No			
E	tal or Attand s after daath al Diractor: , ad in by the f	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (S	At home, farm, stre Specify)	eet, factory, office	28	Bf. Location (Street City or Town, St	and Number or Ru ate)	iral Route Number,
	To the Hospital or At within 24 hours after of To the Funaral Dirac completely filled in by	edical (29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	ysician: To the best of m niner: On the basis of exa and manner stated	y knowledge, death amination and/or inv	occurred at the time restigation, in my op	ne, date and place, ar pinion, death occurred	nd due to the cause d at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the I		29b. Signature and title of certifier			29c. License		29d.	Date signed (Month	o, Day, Year)
)						DU	7720		60/20	101,

Registrar
DHMH 17 Rev 1/2001

State

TIMONIUM, MD 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD.

31. Date filed (Month, Day, Year)

32. Registrar's Signature

JUN 2 8 2004

		•	for State Registrar	State of Ma			nent of H cate of I		nd Mental Hy	Reg. N	ZHHU	20175
	Physici /Medic		1. Decedent's Name (First, Middle, La	REGG					2. Date of D	D	ZOOH	3. Time of Death
	Examin Funeral Director	er	5. Social Security Number 6. S	OIAL	e (In yrs. last birth 76 Y	day) If	City, Town, or Dinder 1 Year onths Days	If Under 24		irth	N/A N/A 9. Birth	nplece (State or Foreign Unity) Carolina
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Locatio	n					10d. Inside City Limits
	Maryl e-f sho	tor	Maryland N/A		Ва	ltin	nore					XXYes 2□No
	with the	1 Direc	10e. Street and Number 4916 Bowland A	venue		10	of. Zip Code	1206			Citizen of What Co USA	untry?
36	72 hours after death with the Maryland natural', or Iteme 23a or 28e-f show dical Examinactional be politied at	by Funeral Director	11. Marital Status 1 Never Married 2 Married **TWidowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 3 1 If Yes, Give Year or Dates:			Decedent of Hi , specify Cuba 'es 2 No	ispanic Origir n, Mexican, f Specify:	n? (Specify Yes or N Puerto Rican, etc.)		14. Race - Ame Black, White	
21215-0036	within ane. than "	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0·12) 12th grade	ducation	(+)	Give kind ife. DO N	Usual Occupion work done of OT use retired	fu <i>ri</i> ng most o	of working		Kind of Business/I	
d 2	be filed tal Hygid d other event, I	Be Co	17. Father's Name (First, Middle, Last			OSIIIe	corog		s Name (First, Middle	e, Maide	en Sumame)	
Maryland	should be nd Mental marked c	10	William Watkin 19a. Informant's Name/Relationship (106	Anilina An			ra Watki or Rural Route Numi		or Town State 7	in Code)
	d 2 s th an th an trau		Jack E. Spain/	• • • • • • • • • • • • • • • • • • • •		_				-		and 21206
Baltimore,	permit. Pages 1 and 2 should Department of Health and Mer Important: If Item 27 Ie marke any injury or other traumatic <u>once.</u>		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Special		20b. Place of I cemetery, Garris	on F	(Name of y or other place orest	vet.	/29/04 Cem.	Owi	Location - City or 1	Town, State
Balti	permit. Pa Departmen Importent: any injury		21. Signature of Funeral Service Lices	1500		^{22. Na}	ne and Addres	ss of Facility terst	Chatman- own Rd E	Har Balt	rris Fur timore,	neral Home Md 21215
98760,	Physician bull sician bull sician and physician and physician and physician site bull	edical Examiner	23a. Pam. Enter the disease, or com shock, or heaft failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as b. Due to (or as c.	ne.	al):	-	_	ARCOMA	arrest,		Approximate Interval Between Opset and Death Weeks
P.O. Box 68	death certif	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death		pic pregnancy er (specify)				23d. Date of deli	very Day Year
	ngi be	by	Part II. Other significant conditions	contributing to death b	ut not resulting in I	he underh	ving cause give	en in Part I.			use contribute to	the cause of death?
I Records,	The ate h page	Completed						·	24a. Wa auto perf 1 □ Yes		prior to c death?	opsy findings available ompletion of cause of
Vita	Physician: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	at 2 EB/Outs	etiont 2	Othe	ac-	Death (Check only		0 Flother (C	4.1
Division of Vital	nding Phys th. r: After this e funeral di	-	27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio	28a. Date of Inju (Month, Da			28c. Injury Work	4 🗆 Nursi	28d. Describe			пу)
Divis	To the Hospitel or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined		ury - At home, farn c. (Specify)	n, street, f	actory, office		28f. Location City or To		and Number or Ruite)	ral Route Number,
	To the Hospitel of within 24 hours af To the Funeral D completely filled in	dicai	29a. Certifier 1 Certifying Pl (Check only 2 Medical Example)	nysician: To the best miner: On the basis of and manner sta	examination and	death occ or investig	urred at the tim pation, in my op	ne, date and pointion, death	place, and due to the occurred at the time	cause(date a	s) and manner as nd place, and due	stated. to the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier	st. ~			29c. License	263	: 4	64	Pate signed (Month	2004
7	V		30. Name and address of person who			ype, Print	PLA	Œ	BACT11	728	E 710	21202
	Sta Registi		31. Date filed (Month, Day, Year) JUN 2 8 201	32. Registra	ar's Signature						(

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) June 23,2004 6;55 A. M **Physician** Giffi Mary Louise /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Reisterstown
If Under 1 Year If Under 24 Hrs. Funture Care Cherrywood Date of Birth (Menth, Day) Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1 □ M 25 F MD 84 22-3596 Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other treumatic event, I'm Medical Evantments. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Md. Baltimore Reisterstown 1 ☐ Yes 2 ☐ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 103 Cherry Valley Road 21136 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2XNo Specify: Specify White þ 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cup Manufacture 12 Packer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Claude Stringer Annie Armstrong P 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert C. Giffi 303 Bluegrass Lane Hampstead, Md 21136 Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 6/28/ 2004 St. Leo Cemetery Ridgway, PA 21. Signatore of Funeral Service License 22. Name and Address of Facility 11824 Reisterstown Road Eline Funeral Home Reisterstown, Md. long Sans 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death diate Cause (Final week **Physician** NOUNCH disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed the attending physician and ched for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the a should be detached t 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. JR A DR 1 | Yes 2 | Ne 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? has certificate 2 No 1 Yes 1 Yes 2 No the Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nersing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28b Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1-Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Homicide within 24 hours a To the Funerel C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mincoure 5 0 MA. n 51 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JUN 2 8 2004

unpend item#23a,27,28a-f,PER ME,C833,7/2/04eg Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Sheree Guyer State of Maryland / Department of Health and Mental Hygiene 04-03965 For State Registrar Certificate of Death Reg. Nó) 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2004 **Physician** Year Sheree N. Guyer June 16, 0727 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Hospital Baltimore Baltimore City 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Hours 1 □ M 2 13 F 24 Yrs. Director 174-64-1245 1980 Chambersburg PA March Usual Residence of Decedent Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ahow other traumatic avant, the Madical Exertiner must be notified at MD Balt. City Baltimore Director tXXYes 2 □ No the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 496 Somerset st. or itams 23c 21202 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No white ģ Specify: 3 Widowed 4 Divorced 'naturai', Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "ne any injury or other traumatic avant, Ita Madis once. (Specify only highest grade completed) Elementary/Secondary (0-12) 10thgrade College (1-4or 5+) student education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ralph Guyer, Jr. Julia Painter ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vanessa Webster - siter 201 Lincoln Way West Apt 3, Chambersburg, PA 17201 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation Serv 6/19/04 Hampstead, MD 22. Name and Address of Facility 11824 Reisterstown Rd Eline Funeral Home Reisterstown, MD 21136 Two art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final Physician Complications of acute narcotic intoxication disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760 physician Physician/Medlcal the attending p IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of defivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 No 24a. Was an 185 autopsy page performed? certificate 1 Yes 2 No Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 XYes 2 No 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After found 6/14/04ar) 1 Natural 5 Pending fourid 6:30p s after decrei Afr 1 Yes 2 No 2 Accident investigation 6基 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 | Homicide other residence 1014 McAleer Court, Baltimore, MD 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) within 2 To tha complet 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)
June 17, 2004 29c. License number OCME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 RUBIO 31. Date filed (Month, Day, Year)
JUN 2 8 2004 32 Registrar's Signature State Registrar

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			1 - For State Registrar	State	of Maryla	ind / Depa <i>Ce</i> a	artmen <i>rtificat</i>					giene Reg. No.	nni.	201	7Ω	
	Physici	an	1. Decedent's Name (First, Midd								2. Date of Dea		2004	3. Time of		
	/Medic	cal	William Micha 4a. Facility Name (If not institution				4b. City,	Town, or	Location	of Death	June	_	2004 County of Death	3:30	Рм	
	- Adimi		Upper Chesape					el Ai					Hari	ford		
	Funeral Director		5. Social Security Number 216-42-9445 Usual Residence of Decedent	6. Sex 1X M 2 ☐ F	7. Age (In yr 60	s. last birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Birtl (Month, Day June	h 13,	9. Birth Cou 1944 Cor	place (State o ntry) nnectic	r Foreign ut	
e Maryland	Ba-f show	Director	MD 10b. County	ford	10c. (City, Town or Lo	cation							10d. Inside Ci	•	
with th	E or 2	Dire	10e. Street and Number 823 Woodmont (Cr.			10f. Zip	Code 2108	25				en of What Cou	ntry?		
5-0036 72 hours after death with the Maryland	or Items 23	Funeral	11. Marital Status 1 □ Never Married 2 ★ Mar	12. Was Dec	2 🗌 No		Was Deced f Yes, spec	dent of Hi cify Cuba		igin? (Spe n, Puerto	ecify Yes or No- Rican, etc.)	1	J.S.A. 4. Race - Ameri Black, White,			
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Maryland 21215-0036	giene. ir than "nai ir e Medic	Completed	(Specify only highe Elementary/Secondary (0-12)	nt's Education est grade completed, College	1-4or 5+)	1	kind of wo. DO NOT us Emp1	rk done d se retired	during mos ()	t of workii	ng		d of Business/Ir .1iard	dustry		
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Mar d 2 sh	th and 7 Is m traum		19a. Informant's Name/Relations Joan Gardiner								r Rural Route Number, City or Town, State, Zip Code)					
Baltimore, I permit. Pages 1 an	20a. Method of Disposition 20b. Place of Disposition (Name of cometery, crematory or other place)										ate	20c. Loc	ation - City or Tidge ,			
Balti Permit.	Departm Importar any injur once.		21. Signature of Funeral Service	-	S M	22	. Name an	d Addres	s of Facilit	y Mil	ler-Dip	pel	Funeral ryland	Home :	Inc.	
/	rysician Medical kaminer		23a. Part 1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a. Hype	each line.	ic Card				cardiac o	r respiratory arr	rest,		Approximate Interval Bety Onset and D	veen	
b, executed	in and ial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	S o	(or as a conse											
	physician s the buris			d	,											
Geath cert	by the attending physicia tached for use as the bur	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		oirth 2 ☐ Fe nant at time of	ital death 3	Ectopic pro Other (sp.					23	3d. Date of delive Month	,	ear	
rdS, P.	gned be de	Aq	Part II. Other significant condition Chronic Alcoholic		eath but not re	esulting in the ur	nderlying ca	ause give	en in Part I.			bacco us	e contribute to tl		eath?	
VITAL RECORDS, P.O.	cate has been si page 2 should b	Completed									24a. Was a autops perform	Sy .	death?	psy findings ampletion of ca	vailable use of	
OT VITA Physician:	certific ector,	Be	25. Was case referred to medica examiner?	Hospital:				Otho	_		(Check only on					
o a	i. After this luneral di	1 Inpatient 2 Let FV Outpatient 3 DOA 4 Nursing Home 5 Resider									/)					
DIVISION Hospital or Attending	s after death	Certification;	3 Suicide 6 Could 4 Homicide determ	not be 28e. Place	of Injury - At ing, etc. (Spec	home, farm, stre cify)	et, factory				28f. Location (Street and Number or Rural Route Number, City or Town, State)				ier,	
ha Hospitu	in 24 hours after ha Funaral Dire pletely filled in b	edical C	29a. Certifier (Check only one) 1 Certifyii 2 Medical	Examiner: On the b	best of my kr asis of examir ner stated.	nowledge, death	occurred a restigation,	at the tim in my op	e, date an	d place, a	nd due to the ca	due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s)				
Tot	within 24	X	29b. Signature and title of certifie	1 1			29c		number	-			signed (Month,	,		
			30. Name and address of person	who completed cau	e) of death (Ite				.C.M.				22, 20			
			THEVOOREN	1, king		11.	1 Pen	n St	reet,	Bal	timore,	Mar	yland 2	1201		
	Sta Registr	33	31. Date filed (Month, Day, Year)	2004	legistrar's Sigr	nature Ap	de									

ROBERT G. HARRIS unpend item#23a,27,28a-f,PER ME,C833,7/2/O4eg Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-04022 RKD State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 18, 2004 8:18P. JUNE ROBERT G. HARRIS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE GOOD SAMARITAN HOSPITAL If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 1 M 2 □ F 48 220-68-5456 MARCH 15,1956 UTAH Director Usual Residence of Decedent Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State or 28a-f show other traumatic event, I've Medical Examiner must be notified at 1 Yes 2 □ No BALTIMORE MD N/ADirector 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Items 23g 21202 U.S.A. 922 SAINT PAUL STREET by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE 3 Widowed 4 Divorced "neturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) MARYLAND PUBLIC Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) SERVICE COMMISSION ASSISTANT MANAGER and Mental Hygir permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Importent: If item 27 1s marked othe any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be MARIAN GRIMES LINCOLN T. HARRIS ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) COCKEYSVILLE, MD 21030 ROBERT C. HARRIS/SON 15 L. BRIDGELAKE CIRCLE 20c. Location - City or Town, State 20b. Pface of Disposition (Name of cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) UNION CEMETERY 6/23/04 BURTONSVILLE, MD 22. Name and Address of FacilityFLECK FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee Sleward 7601 SANDY SPRING RD. LAUREL, MD 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death fmmediate Cause (Final disease or condition resulting in death) Narcotic and Ethanol Intoxication **Physician** /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 attending physician Physician/Medical as the 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 Fetal death Year Month Day in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) ☐ Yes 2 ☐ No P.O. detached 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records. 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Certification: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 □ No 24a. Was an autopsy performed? 12 Yes 2 No To the Hospital or Attending Physician: after death.

Director: After this certific
d in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitaf: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3□ DOA 1X Yes 28b. Time of 28d. Describe how injury occurred Injury at Work? 27. Manner of Death Fourth 6/18/04 5 Pending unknown 1 Natural unknown 1 Tes investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide residence 3900 Chesley Avenue, Baltimore, MD 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date fifed (Month

Me

Day, Year)

JUN 2 8 2004

30. Name and address of person who completed cause of death (ftem 23a) (Type, Print)

RUBIO

MAD 32 Registrar's Signature

SAHL

29c. License number

O.C.M.E.

JUNE 19, 2004

111 Penn Street, Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 2004 Month **Physician** D753AN ROMAN IWASZKO JUNE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** ANNAPULLS

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Mary 3, MAY 3, ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral X**M 2□ F 212-48-8108 58 Yrs. GERMANY Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examinar must be nutified at 1 ☐ Yes 2 No MD. KENT STEVENSVILLE Direct 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 216 BALTIMORE ROAD 21666 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWNER DELMARVA INDUSTRIES 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 Is marked oth any injury or other traumatic event gotes. 17. Father's Name (First, Middle, Last) Be KATERYNA STEPHAN CZMIL IWASZKO ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELIZABETH IWASZKO/ WIFE 216 BALTIMORE RD., STEVENSVILLE, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State A □ Donation 5 □ Other (Specify) MICHAEL'S UKR! BALTIMORE, MARYLAND 6/26/04 22. Name and Address of Facility
LILLY & ZEILER
1901 EASTERN A 21. Signature of Funeral Service Licensee & ZEILER INC. FUNERAL HOME EASTERN AVENUE, BALTO., MD. 21231 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) myecardia A cute Physician /Medical Due to (or as a consequent Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in the cause of the ca Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): P.O. Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 5 Other (specify) should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 3 Probably 4 □Unknown 1 Yes 2 No certificate has been 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1☐ Yes 2≦ No Division of Vital or Attending Physicien: funeral director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 11 Yes 2 No 1 Inpatient this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Natural 5 Pending 1 ☐ Yes 2 ☐ No death. after death 2 Accident investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospitel within 24 hours a To the Funerel I Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medica (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number MD. 2000 7632 2004 J. Cuffern Lowwan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DUNDALK AVE BALTU MD 2/222 2012 OYOWOUAN mD J. CROSSION 31. Date filed (Month, Day, Year) 32. Registrar's Signature 1394EL JUN 2 8 2004 A Septemb Registrar

			1 - State Registrar	- "	of Marylar	nd / Depa		t of H	ealth a			Hygi	_	04	201	8
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>	/Medic Examin	al	Diana Jeweler 4a. Facility Name (If not institution, g	nive street and r	umber)				Location o	of Death	Julie	,		y of Death		
Y - 2.	Funeral		3661 Folley Quar 5. Social Security Number 6	. Sex	7. Age (In yrs.	. last birthday)	If Unde	1 Year	If Under	24 Hrs.	8. Date of	Birth		9. Birth	place (State or F	Foreign
kı Doğumlar	Director		579-09-9625 Usual Residence of Decedent	1□M 2¶F	84	Yrs.	Months	Days	Hours	Min.				New	Haven,	CT
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	death with the Maryland ms 23a or 28a-f show	Director	Maryland Howa	rd	Е.	llicott	10f. Zig					10	g. Citizen of	What Cou	TXT Yes 2	
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	r deat	Funerai	11. Marital Status	12. Was De	cedent Ever in U Forces?	J.S. 13.	Was Dece If Yes, spe	dent of Hi cify Cuba	ispanic Ori n, Mexican	gin? (Spec	cify Yes o Rican, etc.	r No-		ce - Ameri ick, White,	can Indian, etc.	
036	J within 72 hours after dea jiene r than "natural", or Items The Wedikal Examiner "	by	1 □ Never Married 2 □ Married 3 ₩ Widowed 4 □ Divorced	1 □ Yes If Yes, 0 Year or	a 2 ☑ No Give Dates:		1 🗆 Yes	2 X No	Specify:				Speci	∜: Whi	.te	
<u>ب</u>	72 ho natur	eted	15. Decedent's (Specify only highest	Education grade complete	d)	16a. Dece (Give	dent's Usu	al Occupa	ation during mos	t of workin	9	10	6b. Kind of E	Business/In	dustry	
9500-61212	filed within 72 Hygiene ther than "nat ent, the Wedie	Completed	Elementary/Secondary (0-12)	College	(1-4or 5+)	Homen	_	se retired)				Ow	n Hon	ıe	
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	should to and Ment marked umatic a	10	Harry Shapiro			1		12.	Bella				O: 7	O		
ă Z	7 12		19a. Informant's Name/Relationship Steven Jeweler-										City or Town of the Ci		о <i>Соо</i> в) 1D 21042)
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Ē	Pages ment of ent: if it ury or o		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		m State Kin	ng Davi							alls C			
Baltimore,	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service Lie	enside /									li Fun Llver		Home	20904
آر	Physician /Medical		23a. Part 1. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	_ a		2	ter the mo	de of dyin	g, such as	cardiac or	respirato	ry arres	st,		Approximate Interval Betwee Offset and Dea	en ath
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8760,	ate be ohysicia the bur	dical		d												
	he death certificate be executed the attending physician and ched for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 18 menths? 1 Yes 2 No 9 Unknown	1 Livi	outcome of pregree birth 2 Fet Fet Fet Fet Fet Fet Fet Fet Fet Fet	al death 3	⊒Ectopic p ⊒ Other (s							ate of deliv	ery Day Yea	ar
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Vital Records,	Physicien: The law requires that the this certificate has been signed by the director, page 2 should be detach	Completed									а	Was an utopsy performa		Were auto prior to co death? 1 \(\text{Yes}	opsy findings ava impletion of caus 2 No	allable se of
/ita	cien: sartific ector.	Be	25. Was case referred to medical examiner?	Hospital:				Oth		of Death						
0	Phys	. To	1 ☐ Yes No 27. Manner of Death	28a. Da	te of Injury	28b. Time o		28c. Injury	4 □ Nu	rsing Hom			ce 6 □Ot		y)	
0	nding ath. r: Atte ie fune	atior	Natural 5 Pending 2 Accident investiga	(M	onth, Day Year)	Injury	М	Work	k? Yes 2□	No						
Division of	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	Certification:	3 Suicide 6 Could no 4 Homicide determin	ad 289. Pla	ce of Injury - At I Iding, etc. (Spec	nome, farm, st ify)	reet, factor	y, office		2		on (Stre		ber or Run	al Route Numbe	ir.
	To the Hospitel within 24 hours a To the Funeral Completely filled	Medical	29a. Certifying (Check only one) Check only one)	caminer: On the	the best of my kn basis of examin anner stated.	owledge, deat ation and/or in	h occurred ivestigation	at the time, in my of	ne, date an pinion, dea	d place, a th occurre	nd due to d at the ti	the cau	use(s) and m e and place,	anner as s and due t	tated. o the cause(s)	
	To the within To the comple	Me	29th Signature and tell of certifier	201	H,	7	29	c. License	e number			290	d. Date signe	Month,	Day, Year)	
	. !		Stepan 2	flew	FL M	401) [100	53	62	2		6/	10/	04	
	10		30. Name and address of person w	e completed ca	euse of death (Ite	em 23a) (T/pe.	Print	2	(fu	mel	lia	h	10		
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)		Registrar's Sign	nature	ast 1									

Mirt Land, Sack

				State of Ma					-		9		
			For State Registrar	Claro or me	•		cate of			Reg. No		20	100
			Decedent's Name (First, Middle, Last)						2. Date of De	ath		3. Tim	e of Death
	Physici /Media		Jack Boyd Kirt	land					Month	24	y Year	14:0	20 PM
>	Examir		4a. Facility Name (If not institution, give s	street and number)		4b.	City, Town, o	r Location of Dea	ith	40	County of Dea	th	
				e Hosp	ital		ose do	2/6			altim	ore	
	Funeral Director		5. Social Security Number 6. Sex 152	7.'Age	(In yrs. last birth		nths Days	If Under 24 Hr Hours Mir		th ay, Year,	9. Bird	ountry)	ate or Foreign
			Usual Residence of Decedent	3	0				UCL. 22	, 194	45 Ohi	.0	
	rylan how	<u>.</u> .	10a. State 10b. County		10c. City, Town		n					10d. Inside	e City Limits
	Be-f e	cto	Maryland Baltimore		Roseda]	le						101	Yes 2⊠No
	with th	Director	10e. Street and Number	_		10	of. Zip Code			10g. Ci	tizen of What Co	ountry?	
	eath v	Funeral	8826 Philadelphia	Road 12. Was Decedent E	voc in II C	12 14/ /		237	0		S.A.		
10	fter d	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☒ N		If Yes	, specify Cuba	an, Mexican, Pue	Specify Yes or No rto Rican, etc.)	-	14. Race - Ame Black, Whit		١,
93	el', o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 🗆 Y	es 2X No	Specify:			Specify: W	hite	
21215-0036	72 hc	Completed	15. Decedent's Educ (Specify only highest grade		16a. [Decedent's	Usual Occup	ation during most of we	orkina	16b. K	(ind of Business/	Industry	
121	within then.	mpl	Elementary/Secondary (0-12)	College (1-4or 5-	+)	life. DO N	OT use retired	d)	g				
	tiled within 72 hours after death with the Maryland Hygiene ther then "naturel", or Items 23a or 28e-f ehow ont, the Medical Exeminar must be notified at		17. Father's Name (First, Middle, Last)	5+	Tea	acher		18 Mother's Na	me (First, Middle		cation		
au	ld be ental ked o	To Be	William Kirtland					Cathari			oumame)		
Maryland	shou ind M mar umat	_	19a. Informant's Name/Relationship (Typ	oe, Print)	19b. I	Mailing Ad	dress (Street	and Number or R	lural Route Numb	er, City o	or Town, State, 2	Zip Code)	
	and 2 salth a n 27 iv		Beth Kirtland (Wife	e)	88	326 P	hilade:	lphia Ro	ad, Balt	imor	ce, Mary	land	21237
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23a or 28e-f show any injury or other traumatic event, the Martical Examinat must be notified at anotes.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re	amoval from State	20b. Place of I cemetery	Disposition, cremator,	(Name of y or other place	ce)	Date	20c. L	ocation - City or	Town, State	•
<u>ti</u>	ment tent: tent:		`4 ☐ Donation 5 ☐ Other (Specify)		Bayview	v Crei	matory	June	25,2004	Balt	imore,M	aryla	nd
Bal	permit Depar Impor any in		21. Signatura of Funyral Service License	•		22. Nan	ne and Addres	ss of Facility ruzdzins	ki Funer	al F	Home. P.	Δ.	
			23a. Part1. Enter the disease, or complic	cations that caused	the death. Do no	140	7 Old I	Eastern	ki Funer Avenue,	Esse	x, Mary	land	
	Obvolejen		shock or heart failure. List only on Immediate Cause (Final	e cause on each line	9.	ontor the	mode of dyar	g, saon as sarais	o or respiratory a	11631,		Interval	Between nd Death
>	Physician /Medical		disease or condition resulting in death)	Due to (or as a	consequence of)·							
	Examiner			Derfora	ted V	" SCO	115						
	D #	ner	Sequentially list conditions, if any, leading to immediate cauce. Extra Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence of								
	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	metasta	tic non	Sm	ul cel	Llung	canel	-			
760,	icate be executed physician and s the burial-transit	calE		Due to (or as a	consequence of):							
687			d.										
XO	death certifica e attending ph d for use as th	N.	IF FEMALE: 23b, Was decedent pregnant	Bc. If yes, outcome o							23d. Date of deli	VAIV	
m ·	death e atte	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 4 ☐ Pregnant at t			oic pregnancy or (specify)			11	Month	Day	Year
P. 0	at the de by the a stached (hys	9 🗌 Unknown	9□ Unknown									
	The law requires that the tee has been signed by the bage 2 should be detache	þ	Part II. Other significant conditions cont	tributing to death bu	t not resulting in t	he underly	ing cause give	en in Part I.			use contribute to		
Records,	w require been signature	Completed	DVT Left Leg						1	res 2	X No 3∐Pro	obably 4	Unknown
ဒ္ဓင	e law has b	mple.							24a. Was autop	sy	24b. Were aut	topsy finding ompletion o	gs available if cause of
_			75 W							rmed? 2 No	death? 1 ☐ Yes	2□ No	
Vital	Phyeicien: this certificaral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital:	t 2 ER/Outp		Othe		ath Check onl o				
	a ⇒ E	<u> </u>	27. Manner of Death	28a. Date of Injury	28b. Tin	ne of	28c. Injury	at Nursing F	dome 5 Resid			ify)	
Division	Attending F ir death. ector: After by the funera	atio	1 Natural 5 ☐ Pending investigation	(Month, Day	Year) Inju	M M	Work	(? Yes 2 □ No					
<u> </u>	- 0	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injur	y - At home, farm (Specify)	n, street, fa	ctory, office		28f. Location (S City or Tow	Street an	d Number or Ru	ral Route Ni	umber,
	oitel or urs afte rel Dir lled in										, 		
	To the Hospitel or within 24 hours after To the Funerel Dir. completely filled in I	Medical	29a. Certifier (Check only one) 1 Certifying Physi 2 Medical Examin	on the basis of e	examination and/	death occu or investiga	rred at the tim ation, in my op	ie, date and place pinion, death occu	e, and due to the durred at the time, d	cause(s) date and	and manner as place, and due	stated. to the cause	9(s)
	To the Vithin 2 To the complet	Med	29b. Signature and title of certifier	and manner state	eu.		29c. License				e signed (Month		
i	1			m			Don	56296			24-2		
	10		30. Name and address of person who con		ath (Item 23a) (Ty	/pe, Print)	J 30		_			\	
			Dr Jason Birni		7000 F	ank	lin So	mare De	ive Bal	tim	ove M	0 21	237
	Sta Registra	e	31. Date filed (North Day, Year)	32 Registrar	's Signature		me de				,		
	negisti	AU .	0 2007			19 11	20. 00.1	•					

			1 - For State Registrar	State of Marylan	d / Depa	artment		th and N	-	giene		20183
	Physicia		1. Decedent's Name (First, Middle, Last) Lola Loretta Killi	.an			-		2. Date of De Month June	Day 25,	2004	3. Time of Death 6:00 a M
j.	/Medic Examin		4a. Facility Name (If not institution, give sti Manor Care Health S		'n	4b. City, T	TOWSO			4c.	County of Death	
Ē.	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. I		If Under 1 Months		nder 24 Hrs.	8. Date of Bi (Month, Di Sept. 8			place (State or Foreign
	g		Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Lo	cation						0d. Inside City Limits
	he Mar	ector	Maryland Baltimore	e 1	Nottin	gham 10f. Zip (Code			10a Citi	zen of What Cour	1 ☐ Yes 2X No
	death with the Maryland ms 23a or 28a-f show rmust be notified at	al Dir	4405 Hallfield Mano	or Drive		21	1236			τ	JSA	
		by Funeral Director	11. Marital Status 12 1 Never Married 2 Married 3 X Widowed 4 Divorced	2. Was Decedent Ever in U. Amed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decede f Yes, speci 1 ☐ Yes 2		ic Origin? (S) exican, Puerto ecity:	pecify Yes or No Rican, etc.)	0-	14. Race - Americ Black, White, Specify: Whi	etc.
0-6171	filed within 72 hours after Hygiene. other than "natural", or its ant. the Medical Examina	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	(Give	dent's Usual kind of work DO NOT use memake		most of wor	king		nd of Business/Ind Home	dustry
land 2		To Be Co	17. Father's Name (First, Middle, Last) Charles Senft				18. N	Mother's Nam	ne (First, Middle ence	, Maiden	Sumame)	
Mary	s 1 and 2 should I Health and Men Item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type Mary Smith (Daughte			-				-	r Town, State, Zip am, Md.	
ore,	00-		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Re	20b. P	lace of Dispo			C /20	Date		cation - City or To	
baltimor	permit. Pege Department o Importent: If any injury or once.		*4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee		dens C			6/28/	1 Home	L	imore, M	arytand
ם	88 28		23a. Part. Enter the disease, or complic snock, or heart failure. List only one	Acuste ations that caused the death	1	407 O	ld East	tern A	<u>venue E</u>	ssex	, Md. 21:	Approximate Interval Between
	Physician /Medical Examiner portion and private transit	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to	uence of):	- 4	- fai	,				Onset and Death
BOX 68/6U,	death certificate be executed e attending physicien and of for use as the burial-transit	edical	IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome of pregna	incy _	35					23d. Date of delive	ary
Ď Ċ	that the death led by the atte detached for	Physician/M	in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live birth 2 Fetal 4 Pregnant at time of de		Ectopic pre Other (spe					Month	Day Year
cords, r	w requires that been signed b should be deta	by	Part II. Other significant conditions cont	inbuting to death but not resi	ulting in the u	nderlying ca	use given in F	Part I.	i	tobacco u Yes 2		ne cause of death? pably 4 □Unknown
Ľ	The law ate has b	Completed							24a. Was auto perfi 1 Yes		24b. Were auto prior to con death? 1 ☐ Yes	psy findings available mpletion of cause of No
VII	Physician: rthis certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 Inpatient 2	ER/Outpatier	nt 3□ DO/	0.4		th (Check only ome 5 Res		5 ☐Other (Specify	y)
ion or	fe e	ation: T	27. Manner of Death 1 A Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 28	Bc. Injury at Work? 1 ☐ Yes	•	28d. Describe			
DIVISION	i Ditto	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify		eet, factory.	, office		28f. Location (City or To		d Number or Rura)	l Route Number,
	To the Hospitel within 24 hours a To the Funeral completely filled	Medical		ician: To the best of my kno er: On the basis of examina and manner stated.								
	To the within To the	Me	29b. Signature and title of configur				License num			29d. Dat	e signed (Month,	Day, Year)
	1		30. Name and address of person who con	mpleted cause of death (Item		Print) D	achad i		M.D.21		40/00	7
	Sta	ate	7505 OKE Dr. 31. Date filed (Month, Bay, Year) JUN 2 8 2004	32 Registrar's Signa	ture	Son	~	ny	21	04		
	Registi	rar	JUIT N 0 2004	pull server	13	dow.	1					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2004 **Physician** June 7:55 Ρм Edward P. Knight /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Linthicum Anne Arundel 10 Mansion Road If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 XM 2 ☐ F 213-64-0707 Director Jan 17, 1953 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County r then "natural", or Items 23s or 28s-f show The Madical Extraprets ust be notified at 1 ☐ Yes 21 No Maryland Anne Arundel Linthicum Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21090 United States 10 Mansion Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status □Yes 2X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🎉 No Specify. If Yes, Give Year or Dates: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h. Kind of Business/Industry at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Auto Repair Mechanic 12 Injury or other treumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked of Pages 1 end 2 should be Leona L. Lehmuth Melvin G. Knight, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 s Depertment of Health ar Importent: If Item 27 is any Injury or other treu 94 Rowell Road, New Port, New Hampshire 03773 Kathy A. Walsh / Cousin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Loudon Park Cemetery 6/29/2004 Baltimore, Maryland ' 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Atheroscienti cardiovascular disease **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as t IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by d be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cinhosis and fatty change of hirer 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ▼Yes 2 □ No 24a. Was an chronic alcoholism autopsy performed? 1 Yes 2 ☐ No 25. Was case referred to medical examiner?
1 Yes 2 □ No 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 \sum Nursing Home 5 Residence Cother (Specify) at scene ပို 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation I Director: A d in by the fo 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide To the Hospitel o within 24 hours eff To the Funerel Di completely filled in 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number O.C.M.E. June 26, 2004 Greenberg NED 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D 7 lasha Greenberg 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

JUN2 8 2004

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ORIGINAL

Be Completed by Physician/Medical Examiner P Certification:

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after death.

Director: After this certific
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within 24 hours a To the Funeral C

į,	Immediate Cause (Final disease or condition	a. Sudden Unexplain	ed Death in Infa	ncv		Onset and Death
	resulting in death)	Due to (or as a consequence of):				
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b				
dicai Exa	resulting in death) Last	c Due to (or as a consequence of):				
Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		Ectopic pregnancy Other (specify)		23d. Date of deliv Month	rery Day Year
ted by PI	Part II. Other significant conditions	contributing to death but not resulting in the un	iderlying cause given in Part I.		. 1	the cause of death?
Comple				24a. Was an autopsy performed?	prior to co	opsy findings available impletion of cause of
Be	25. Was case referred to medical examiner?			ath (Check only one)		
P	XXYes 2 No	Hospital: 1 ☐ Inpatient 2 🕅 ER/Outpatient	3 DOA Other: 4 Nursing H	Home 5 Residence	6 ☐ Other (Specif	(y)
on:	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury 28b. Time of (Month, Day Year) Injury	28c. Injury at Work?	28d. Describe how injur	y occurred	
atl	2 Accident investigation	Found Found	M 1 ☐ Yes 2 X No	Unknown	Ti.	
Sertifle	3 🗍 Suicide 6 🗷 ould not t 4 🗍 Homicide determined	building, etc. (Specify) Found At. Resider	nce	28f. Location (Street and 1228 McCull	oh St Ap	ot A
Medical Certification:	29a. Certifier (Check only one) 1 Certifying P Medical Exa	hysician: To the best of my knowledge, death iminer: On the basis of examination and/or inversal and manner stated	occurred at the time, date and place	Baltimore a, and due to the cause(s) urred at the time, date and	Maryland and menner as s place, and due to	tated. o the cause(s)
×	29b. Signature and title of certifier		29c. License number	29d. Dat	e signed (Month,	Day, Year)
	•	1 Ups	OCME	JUN	E 20, 2	2004
	30. Name and address of ferson who	Completed case of death (Item 23a) (Type, P	Print) P en n Street, Balt	imore, Marv	land 2120	01
te ar	31. Date filed (Month, Dalv, Year) JUN 2 8 2004	32. Hegistrar's Signature	load	•		

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1X Yes 2 No

State

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death June 23, 2004 **Physician** Marjorie Helen Lease 1:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Franklin Square Hospital Center Rosedale Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nov. | 7, 1931 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign Country) West Virginia **Funeral** 1 ☐ M 2 🖫 F 212 28 8066 72 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, The Muslical Expring marked by the Muslical Expring. 10a, State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 7 is markad other than "natural", or Itams 23a or 28a-f shov traumatic event, the Modical Exertinal must be notified at Director Maryland Baltimore 1 ☐ Yes 2 ☐ No Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6801 South River Drive 21220 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White à 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Beautician Salon 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be (unkonw) ပ Oleta Reed 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lester B. Lease (husband) 6801 South River Drive Baltimore, Maryland 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State tX Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or Holly Hill Mem. Gardens 6/26/04 Baltimore Co., Maryland ¹ 4 □ Donation 5 □ Other (Specify) 21. Sign ture of Fun a al 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex Maryland 21221 23a. Part 1 Enter the disease, or conshock, or heart failure. List only plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cardiopulmonary Arrest disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Metastatic Sarcoma Sequentially list conditions, if any learning to mind cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to [or as a consequence of Hospital or Attanding Physician: The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months?
1 Yes 2 No Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗌 Unknown à sate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. Be Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy pertormed? Yes 2 X No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 X ER/Outpatient This 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Diractor: the 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MADHU CHAUDHRY GBMC Cancer center, 6569 N Charles ST BAUTIMORE MD21204 31. Date filed (Month, Day 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	ale oi iviai	•	e <i>rtificate of</i>	Death		gierie Reg.N⊚ Ո ∩ :	20107
		_	Decedent's Name (First, Middle, Last)					2. Date of De Month		-3. Time of Death
	Physicia /Medic	_	STELLA LAMM					June	24, 20	004 16:12 M
	Examin	100	4a. Facility Name (If not institution, give stree	t and number)		4b. City, Town,	or Location of Death		4c. County of	Death
			2253 Cedley Street			Balti				
	Funeral Director	-3-5	5. Social Security Number 6. Sex 1 M		in yrs. last birthda 90 Yrs.	y) If Under 1 Year Months Days		8. Date of Bir (Month, Da AUGUST	th y, Year) 14, 1913	Birthplace (State or Foreign Country) MARY LAND
	pug *		Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town or	Location				10d. Inside City Limits
	sho	5				RE CITY				X1√2 Yes 2 No
	28a-f	ect	MD 10e. Street and Number		DALITRO	10f. Zip Code			10g. Citizen of Wha	
	E or	ä				101. Elp 0000	21230		USA	ar obunity.
	leath	era	2253 CEDLEY STREET 11. Marital Status 12. V	Vas Decedent Ev	er in U.S. 1	3. Was Decedent of		ecify Yes or No		American Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "naturel", or Items 23c or 28a-f show any injury or other treumatic event, I'm Medical Evairin at Irasi Lie mullified at once.	by Funeral Director	1 Never Married 2 Married 1	Armed Forces? ☐ Yes 2XXNo F Yes, Give fear or Dates:		If Yes, specify Cub 1 ☐ Yes 2 XXVo	Hispanic Origin? (Spi an, Mexican, Puerto Specify:	Rican, etc.)	Specify:	White, etc.
2-0	72 ho	ited	15. Decedent's Educatio (Specify only highest grade cor	n noleted)	16a. De	cedent's Usual Occu	pation during most of work	ina	16b. Kind of Busin	ness/Industry
21	ithin in ith	Completed by		College (1-4or 5+)	life	. DO NOT use retire	d)	9		
21	ygier ygier her th		8			NURSING	40 Mathada Nasa	/First Middle		GOVERNMENT
and	be fi	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name		Maiden Surname) CE BUCKLEY	
Ĕ	d Mer nark	2	AUGUST SCHUH 19a. Informant's Name/Relationship (Type, F	Orint1	10h Ma	iling Address (Street	and Number or Rura			ato Zin Codol
Maryland	d 2 s th an th an treur		PHYLLIS MARIE LAMM	inty	155.1912		atapsco Aven			
	t an Heal tem 2		20a. Method of Disposition			position (Name of		ate Du I	20c. Location - Cit	
Baltimore,	ages ant of it: If I		1 XeXurial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	val from State		rematory or other pla	^{∞9)} L PARK 6/28/	2004	GLEN BURNIE	F. MARYLAND
量	nit. Fartme		21. Signature of Funeral Sin ice Licensee	0			ess of Facility FI			- ,
ñ	Depar Impor any ir		KELLY GREGORY FINK	#M01148		426 CRAIN	HIGHWAY S.,	GLEN BURN	NIE, MARYLAN	ND 21061
	- 5		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one care	ns that caused th	e death. Do not e	enter the mode of dy	ng, such as cardiac o	or respiratory a	rest,	Approximate Interval Between
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	/Medical		resulting in death)		consequence of):	110000300	C10/(C 04)		SEASE	
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	po tis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a o	consequence of):					
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Records,	w requir s been si should	Completed						24a. Was	an 24b. Wer	e autopsy findings available
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n of	a = 0		27. Manner of Death 1 Aatural 5 □ Pending	Ba. Date of Injury (Month, Day Y	(ear) 28b. Time	of 28c. Inju	ry at :	28d. Describe h	now injury occurred	
Sio	Attending ir death. ector: After by the fune	atle	2 Accident investigation			M 1	Yes 2□No			
Division	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28	Be. Place of Injury building, etc. (- At home, farm, (Specify)	street, factory, office	1	28f. Location (5 City or Tox		or Rural Route Number,
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	pitel ours a eral C		30a Configur 1 Certifying Physicia	B: To the best of				and due to the t	Jause(s) and manne	
	the Hospitel nin 24 hours a the Funeral E			n: To the best of to On the basis of example and manner state	kamination and/or	investigation, in my	ppinion, death occurr	ed at the time,	date and place, and	due to the cause(s)
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: Atter completely filled in by the funer	Medical C	(Check only 2 Medical Examiner:	On the basis of ex	kamination and/or	investigation, in my	opinion, death occurr se number	ed at the time,	date and place, and 29d. Date signed (M	due to the cause(s) fonth, Day, Year)
			(Check only one) 2 Medical Examiner: 29b. Signature and title of certifier	On the basis of ex and manner state	xamination and/or d.	29c. Licens	ppinion, death occurr	ed at the time,	date and place, and	due to the cause(s) fonth, Day, Year)
)	To the Hospitel within 24 hours a To the Funeral E completely filled		(Check only one) 2 Medical Examiner: 29b. Signature and title of certifier 30. Name and address of person who completed	On the basis of ex and manner state	kamination and/or d. th (Item 23a) (Typ	29c. Licens e, Print)	opinion, death occurr se number	ed at the time,	date and place, and 29d. Date signed (No. 30 June 25,	due to the cause(s) Honth, Day, Year) 2004

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) June 25, **Physician** 200⁴a 5:15 p м Hattie Belle Lilly /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 6107 Hunt Club Road Elkridge Howard If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 2 F Months 218-12-8560 91 Director JUL 27, 1912 Maryland Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√☐ No Director Maryland Howard Elkridge 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6 6107 Hunt Club Road 21075 USA items 23a Pages 1 and 2 should be filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 4 Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 TNo Specify. Specify: White þ 3 □ Widowed 4 □ Divorced 'natural' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) marked other than Machinist Westinghouse 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and Mental Fannie Stull William Miller ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a important: if item 27 is any injury or other trau once. Nancy L. Nicholson/daughter 6107 Hunt Club Road Elkridge, MD 21075 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🏹 Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 6/26/04 Baltimore, MD 21. Signature of Juneral Service Licenses C

Dawn F. McDonald Cremation Society of Maryland, Inc. Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Parkinsoula averosilente years Immediate Cause (Final Enysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760, physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ② No Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. I the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 【Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 22 No 1 ☐ Yes Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Tes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; After 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide thin 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical the within 7 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier (harles e 26, 2004 30. Name and address of person who completed care of death (Item 23a) (Type, Print) CHARLES R. GRAHAM JR 1001 PINE HELENTS AVE, 5300 BALTIMORE 32: Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			For State Registrar	State of	Maryland		artment of Hortificate of E		ental Hygie	0001	20189
	Physici	an	1. Decedent's Name (First, Middle, L	2GV2Y				-	Data of Dooth	Day Year	3. Time of Death 9.05 PM
	/Medic Examin	er	4a. Facility Name (If not institution, g		ber) ended C	1.12	4b. City, Town, or Baltin	Location of Death		4c. County of De	ath
	Funeral Director		213-10-8555	Sex 7	7. Age (In yrs. la 92	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. 8 Hours Min.	B. Date of Birth (Month, Day, Ye Aug 5, 19	9. Bi	rthplace (State or Foreign Jountry) aryland
	land Dw		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	ocation				10d. Inside City Limits
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	th with the 23a or 28a	al Direc	10e. Street and Number 302 Waterview Co	ourt			10f. Zip Code	1074	10g.	. Citizen of What C USA	country?
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Experiment must be recitied at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced	12. Was Deced Armed Ford 1 1 Yes 2 If Yes, Give Year or Dat	ces? 2 ☐ No		Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 ☑ No		ify Yes or No- ican, etc.)	14. Race - Am Black, Wh Specify:	
2-0	72 ho	eted	15. Decedent's (Specify only highest of	Education rade completed)		(Give	dent's Usual Occupa	uring most of working	161	b. Kind of Busines	s/Industry
121	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) College (1-									Retail	Business
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/lan	2 should be tand Mental I is marked or aumatic eve	To B	William Leavey					Lena Gol	dberg		
, Maryland	1 and 2 sho Health and I tem 27 is ma		19a. Informant's Name/Relationship Wendy Hutchins,			302	ng Address (Street a Waterviev	Court, H	ampstead	, MD 210	74
Baltimore,	permit. Pages 1 a Department of Hei Important: ff item any injury or othe once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 1 ☐ Donation 5 ☐ Other (Special Content of the Content	□Removal from S	tate C6	metery, cre	osition (Name of matory or other place Forest Ve	0.00		c. Location · City o Owings I	r Town, State Mills, MD
Balti	permit. Pages Department of H Important: if ite any injury or of		21. Signature of Firm red Service Lice	ensee 5/1	123 W	2	2. Name and Address 934 South	s of Facility E. Main St,		eral Home ad, MD 21	
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	Physician	N	Immediate Cause (Final disease or condition resulting in death)	a. My	ocard	ial	Intare				Onset and Death
ı	/Medical Examiner		resulting in dealing	Due to (o	ras a consequ	ence of):	Herry [) LERGE			
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8760,	ate be executed thysician and the burial-transit		resulting in death) Last	Due to (c	r as a consequ	ence of):					
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ord	w require been sig should b	eted			·				24a. Was an		
Vital Records,	The lav ate has page 2	Completed							autopsy performed	death?	
/ita	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Otho	26. Place of Death (-
of	Phys this al di	T. To	1 ☐ Yes 2 ☑ No 27. Manger of Death	28a. Date of	Injury	ER/Outpatie 28b. Time o		4 Nursing nome	e 5 Residence 3d. Describe how i	e 6 □Other (Speinjury occurred	ecify)
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Division	To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	Certification;	3 Suicide 6 Could not determine	d 286. Place (of Injury - At hor g, etc. (Specify	me, farm, st)	reet, factory, office	28	3f. Location (Stree City or Town, S		Rural Route Number,
	ne Hospit 24 hour ne Funera	Medical (sis of examinati		h occurred at the time exestigation, in my op				
)	within to the sound of the soun	W	29b. Signature and title of certifier	Wul	M	M.D	29c. License	number 365	29d.	Date signed (Mon	in, Day, Year) 5, 2004 MD, 21218
_	10,		30. Name and address of person who George E. Wic	completed cause	of death (Item	23a) (Type,	Loch Rai	ien Boule	vard, Bo	attimore	MD 21218
	Sta Registi		31. Date filed (Month, Day, Year)		gistrar's Signat	ure					
DH	MH 17 Rev 1/2		JUN 2 8 20	U4	was D	Sign	Me)				<u> </u>
						DRIGIN	AL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM 19E PER FH, G832, 06, 28, 04, 14, 15

Bed. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 12:55 PM BERNICE MURCHIN JUNE 26 2004 Α. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner FUTURE CARE AND REHAB, OF CANTON BALTIMORE N/A Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 28 1919 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Days **Funeral** Months 1 □ M 2 🔽 F 212-07-5703 85 Maryland Director Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location with the Maryland 10b. County 10a State ir than "natural", or items 23e of 28e-f show the Medical Exam in must be notified at 1 Yes 2 No **Baltimore** Director n/a Md. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 1 West Conway Street Apt. 1005 21201 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give ↑ Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify. Specify: white þ 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) other than Elementary/Secondary (0-12) Food Service Restaurant Manager 11 or other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Heath and Mental Hy important: If tem 27 is marked othe any injury or other traumatic event. 17. Father's Name (First, Middle, Last) Be Vera Petz Harry Klemm 19b. Mailing Address (Eligor and Number of Bural Court, Wysber, Ein or Town, State, Zip Code)
9756 White Water Court, Las Vegas Nevada 8 19a. Informant's Name/Relationship (Type, Print) Harry Murchin (Son) 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition leade of Disposition (Name of commetery, crematory or other place)

loudon Park Cemetery 07/01/04 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Md. * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Name and Address of Facility
McCully-Polyniak Funeral Home P.A.
130 E. Fort Ave. Baltimore, Md. 21230 Deorge M. Hampton 23a. Part1. Ent if the disease, or commerciations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final WONT HO DIANT FAILULE Physician SULFITIVE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exan iner Hospitel or Attending Physician: The law requires that the death certificate be executed burial-trarisi and Due to (or as a consequence of): attending physicien of Vital Records, P.O. Box 68760, Physician/Medical as the 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Month Day jo in the past 12 months? 5 Other (specify) 1 Yes 2 No the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by should be 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably MELLITUS ABCTE peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? filled in by the funeral director, page 2 1 ☐ Yes 2 ☐ No 1 Yes 2 NO certificate 25. Was case referred to medical examiner? 26. Place of Death Check on one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death After Division 1-Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after deat To the Funerel Diractor: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier npletely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier TO T U)aks JUNE 18 1004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALGEM TOWNOW MAD TANU uno 7505 03150 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 2 8 2004 Registrar

		1- For Amend Item 1 Registrar		Ce	піпса	te of C	eaith and Death		Reg. No	2011	2019
Physic		1. Decedent's Name (First, Middle, Las	James W. M	oore Jr	•			2. Date of De Month	ath UC Da	0/25/04 ly Yea	
/Medi Exami		4a. Facility Name (If not institution, give	street and number)		4b. Cit	, Town, or I	ocation of De	ath	40	. County of De	eath .
		, , ,	ounty		_	Lumbia					l County
Funeral Director		5. Social Security Number 6. Security Number 216–38–3831	7. Age (In yrs	s. last birthday) Yrs.	Months		If Under 24 H Hours M		iy, Year,	941 Ma	lirthplace (State or Fore Country) aryland
/land		10a. State 10b. County	10c. C	City, Town or Lo	cation						10d. Inside City Limi
e-fsh	ctor	Md. Howard C	ounty G	Glenwood	i						1 □ Yes 2 \ □ N
h with the 23a or 28 at be no	al Dire	10e. Street and Number 3697 Sharp Road			10f. Z	ip Code 21738	}		10g. Ci	tizen of What (,
s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s or 28e-1 show other treumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:		fYes, sp	edent of His ecify Cuban 2 X No	, Mexican, Pu	(Specify Yes or No erto Rican, etc.))-	14. Race - An Black, Wh Specify: V	
72 ho	Completed	15. Decedent's Edi (Specify only highest grad				ual Occupat	ion iring most of w	vorkina	16b. K	ind of Busines	s/Industry
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filed v Hygie sther t	e Co	12 17. Father's Name (First, Middle, Last)	+4	Chie	et Ei	nginee		ame (First, Middle,			nway Admin.
should be and Mental marked o	To Be	James W.	Moore Sr.				Eunic	e		Sheeha	
1 and 2 sho Health and em 27 is ma		19a. Informant's Name/Relationship (T Katherine L. Moor	e (Wife)	369	7 Sha	arp Ro	oad, G1	enwood Mo	er, City o	or Town, State, 1738	Zip Code)
permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr angle.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ I 1 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State	Place of Dispo cemetery, crem len Hav	natory or	other place,		Date 06/29/04		ocation - City o n Burni	
permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Licens	2 CHANA	1 22	Name a McCi	ind Address	of Facility olynia	k Funeral oad, Pasa	L Ho	me P.A.	21122
Pnysician /Medical Examiner	her	23a. yart1. Enter the disease, or comp shock, or heart failure. List only of principal sease or condition resulting in death) Sequentially list conditions if any, leading to immediate the list of the conditions. Etc. In ordinary Cause (Disease or injury)	a. Carda Conse						rest,		Approximate Interval Between Onset and Death
The law requires that the death certificate be executed the has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	dicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conse								
it the death certific by the attending p tached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 🗌	Ectopic p Other (s	pregnancy				23d. Date of de Month	elivery Day Year
quires lha en signed l uld be det	۵	Part II. Other significant conditions co	ntributing to death but not re	sulting in the ur	nderlying	cause given	in Part I.	23e. Did to	-		to the cause of death? Probably 4 □Unknow
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Physician: This certificated fall director, p	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	∃ER/Outpatien	3 D	Othor		eath Check only of			
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of or Attending after death. Director: After In by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, stre ify)			2 2 3 1 1 1	28f. Location (S City or Tow	itreet an n, State	d Number or A	lural Route Number,
o the Hospitel or At thin 24 hours after of the Funerel Direct mpletely filled in by	Medical C	29a. Certifier Certifying Phy	sician: To the best of my kniner: On the basis of examinating and manner stated.	owledge, death ation and/or inv	occurred	at the time, in my opin	date and place ion, death occ	se, and due to the d surred at the time, of	cause(s). date and	and manner a place, and du	s stated. e to the cause(s)
To the h	Me	29b. Signature and title of certifier			29	c. License r	umber	2	29d. Dat	e signed (Mon	th, Day, Year)
(X)	1	20 Name and address of	The sylving of the sy	2000		000	589	345	6	/26/	104
W'		30. Name and address of person who co	3501	011		1	/-	5	¥e	201	111,000
Sta Registi		JUN 2 8 2004	37. Registrar's Sign	ature	doa	de		City	1	10 21	1072

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State AMEND ITEM #19A, PER FH, G832, 6/28/19/10/16 of Death 3. Time of Death 5:47 A 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2004 ear **Physician** 22, June James Preston Melton, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A MAR Joseph Richey Hospice Baltimore 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**⊡**M 2□F Months 212-48-1249 1949 Maryland 55 Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State Nes 2 No N/A Baltimore Maryland Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 513 N. Pulaski Street 21223 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 ☐ No Specify Specify: Black Completed by 3 Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Mariner Nursing Custodian Home 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James P. Melton, Alberta Bell Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Intormant's Name/Relationship (Type, Print)
7. ANNIS LEACH SISTER 805 N. Woodington Rd Baltimore, Maryland itam 27 i S 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20a. Method of Disposition 20c. Location - City or Town, State AME Department of H Important: If ita any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Zion Cemetery 6/26/04 Baltimore, Maryland 21. Signature of Funeral Service Livensee 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 21215 Than Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disea e or condition resulting in death) holangio carcinoma with months Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, to amy to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequenna of) Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of). Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 ther (Specify) 1 ☐ Yes 2 No 2 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 5 Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funaral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier SO MO

Registrar DHMH 17 Rev 1/2001

State

Baltimore MD 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E. To MD Riches Hospice 838 N

Hospice 32. Registrar's Signature

m		for State	State of Maryland				, ,	~ ^	01	001	^ ^
		Registrar 1. Decedent's Name (First, Middle, L.	ast)	00	Tuncate of t	Jean			UH	3. Time of	Death
Physic		Joe	Fdward		McC1	arv	Reg. No. 0 22 2004 8 2. Date of Death June 23 2004 8 n of Death June 23 2004 8 n of Death June 23 2004 8 n of Death N/A ar 24 Hrs. 8. Date of Birth (Month, Day, Year) 12 26 35 SC 10d. In 1 10g. Citizen of What Country? U.S.A. Digin? (Specify Yes or No-an, Puerio Rican, etc.) Digin? (Specify Yes or No-an, Puerio Rican, etc.) Trucking Comer's Name (First, Middle, Maiden Surmame) Trucking Comer's Name (First, Middle, Maiden Surmame) The Palsey Date 20c. Location - City or Town, State, Zip Code Roade, Baltimore Md 21 Date 20c. Location - City or Town, State, Zip Code The Palsey 20c. Location - City or Town, State, Zip Code Roade, Baltimore Md 21 Scardiac or respiratory arrest, Property of Seath (Property North Day) 1. 23e. Did tobacco use contribute to the cause of Death (Check only one) 1. 23e. Did tobacco use contribute to the cause of Death (Check only one) 1. 23e. Did tobacco use contribute to the cause of Death (Check only one) 1. 23e. Did tobacco use contribute to the cause of Death (Check only one) 23d. Date of delivery North Day 23d. Date of delivery North Day 24d. Were autopsyfinite one 25d. Date of Check only one) 1. 23e. Did tobacco use contribute to the cause of Death (Check only one) 25d. Date of Death (Check only one) 25d. Date signed (Month, Day, Young) 25d. Date signed (Month, Day, Young) 25d. Date signed (Month, Day, Young) 25d. Date signed (Month, Day, Young) 25d. Date signed (Month, Day, Young) 25d. Date signed (Month, Day, Young) 25d. Date signed (Month, Day, Young) 25d. Date signed (Month, Day, Young) 25d. Date signed (Month, Day, Young) 25d. Date signed (Month, Day, Young)	8:37	PN		
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\$ \frac{1}{2} \frac{1}{2}	ıtlon; To		1 ☐ Inpatient 24 El 28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injury Work	at ?)	
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3+1		S.R. HOGY	40	11.	l Penn St	reet, Bal	Ltimore,	Maryl	and 21	.201	
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Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland C. A. A. A. A. A. A. A. A. A. A. A. A. A.	=xaiiiii		Bon Secours Ho	spital		Baltim				
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Mar			19a. Informant's Name/Relationship						er, City or Town, St	
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	. 7		30. Name and address of person wh	AMB E	SON SECT	0 1	OSPITA	L Ba	Stino	e MD
	Sta Registr		31. Date filed (Month, Day, Year)		ar's Signature	boaks				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month James L. Mace, Sr. June 2004 5:48 a.m /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Gilchrist Center Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 18 M 2□F 232-32-1755 76 Yrs Director Dec. 6, 1927 West Virginia Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "naturel", or items 23e or 28a-f show other treumstic event, the Medical Examiner must be righted at 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1718 Woodland Drive 21222 United States Funerai death 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑¥es 2 □ No If Yes, Give WW II Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. e filed within 72 hours after of Hygiene. I Hygiene." naturei", or iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White φ 3XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturer-Production Mechanic 8 years Manufacturing 17. Father's Name (First, Middle, Last) s 1 and 2 should be fill I Health and Mental H tem 27 is marked otf 18. Mother's Name (First, Middle, Maiden Sumame) Truman C. Mace Hattie Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other trei Jeannette Alex (Daughter) 5046 Brightleaf Court Baltimore, Maryland 21237 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Surial 2 ☐ Cremation 3 ☐ Removal from State `4 ☐Donation 5 ☐ Other (Specify) Holly Hill Mem. Gardens 6/25/2004 Middle River, Md. 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** laricea bleeding DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Alcoholic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 5 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOTO Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Certification: To the Hospitei or Attending 1/Natural Injury death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: filled in by the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after 4 - Homicide Funerei 29a. Certifier 🔁 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the pest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the within 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 58303 JUNE 22 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) enotes St Baltmore mo Avail Charles, mo 600 NIC 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JUN 2 8 2004

MACE, JAMES

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			1 – For State Røgistrar	State of Maryl		artment of H			iene	20100
	Physici /Medic	al	Decedent's Name (First, Middle, Last) Tvan Monto 4a. Facility Name (If not institution, give s	alvo		4b City Town or	Location of Death	2. Date of Death Month		
	Funeral	ier	BALTIMURE VAI 5. Social Security Number 6. Sex	Medica CC	Ven ter vrs. last birthday)	BA CHI If Under 1 Year Months Days	MORRI If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Vear) 9. Bir	thplace (State or Foreign
	Director Mou		Usual Residence of Decedent 10a. State 10b. County	-	O Yrs. City, Town or Lo	ocation		MAR 17,	1964 Pue	rto Rico 10d. Inside City Limits
	ith the Ma or 28e-f s e notified	Director	Maryland N/A 10e. Street and Number			Baltimo 10f. Zip Code	re	10	Og. Citizen of What Co	1 XYes 2 No ountry?
936	hours after death with the Maryland tural', or Items 23e or 28e-f show at Examiner must be notified at	by Funeral I	2808 Gibbons A 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☑ Yes 2 ☐ No 1	981 -	Was Decedent of Hi f Yes, specify Cuba		ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:	
Maryland 21215-0036	d within 72 jiene. r than "na If a Medic	Completed	15. Decedent's Edu (Specify only highest grade	cation	16a. Dece (Give life.	dent's Usual Occupa kind of work done o DO NOT use retired	furing most of work)	ing 1	United S	rindustry
yland	e d la	To Be (17. Father's Name (First, Middle, Last) Ivan Montalvo					e (First, Middle, M nelia Per	laiden Sumame)	<i>J</i>
Baltimore, Mary	of Health a of Health a fitem 27 is		19a. Informant's Name/Relationship (Ty) Ana Amelia Perez/m 20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ R	nother 200	4456 b. Place of Dispo cemetery, crer	Salud Sta sition (Name of natory or other place	ation May	Aguez, P	City or Town, State, 2 Uerto Rico Oc. Location - City or	0.0680
Baltim	permit. Pag Department Important: I any injury o		4 □ Donation 5 □ Other (Specify) 21. Signature Funeral Service License Dawn F. McDo	anald Male		ematory, Name and Address Tremation 299 Freder	i i		Baltimore, and, Inc. ore, MD 21	, MD 228
	Pnysician /Medical Examiner	her	23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury)	Due to (or as a cons	Immune sequence of):	er the mode of dying	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
x 68760,	the death certificate be executed y the attending physician and iched for use as the burial-transit	/Medical Examiner	resulting in death) Last	Due to (or as a const.						
.O. Box	that the death ed by the atten detached for u	Physiclan/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	very Day Year
ecords, P	requires een sign	by	Part II. Other significant conditions con	tributing to death but not	resulting in the ur	nderlying cause give	n in Part I.	23e. Did toba	acco use contribute to	the cause of death?
α	The law ate has b page 2 sl	Completed	05 W						ed? prior to death? X No 1 □ Yes	topsy findings available completion of cause of 2 No
Division of Vital	ing Phys After this uneral dis	ertification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	ospital: 1 TInpatient 2 28a. Date of Injury (Month, Day Year	ER/Outpatien 28b. Time of Injury	28c. Injury Work	r. 4 Nursing Ho	me 5 ☐ Residen 28d. Describe how	ice 6 Other (Spec	sify)
Divis	Hospitel or Attend 4 hours after death Funeral Director: / tely filled in by the f	O	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, streecify)	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	Medical	one)	icien: To the best of my liter: On the basis of exam and manner stated.	knowledge, death ination and/or inv	estigation, in my op	inion, death occurr	ed at the time, dat	e and place, and due	to the cause(s)
ì	Mili Cor	~	29b. Signature and title of certifier School Bandare N	reigh MD		29c. License			d. Date signed (Month	
(otl		30. Name and address of person who con Ilian Bandarana	mpleted cause of death (I	tem 23a) (Type,	Print) NO-Ree	Ne Stee	et BAL	Homore, M	102/201
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sig		P. J.				

		•	For State Registrar	State of M	laryland		artment of H		nd Me		jiene	0.01.	20100	
			Decedent's Name (First, Middle,	Last)					2	. Date of Dea	th	<u> </u>	3. Time of Death	
	Physici /Medic		Joan		Overk	0				June	25 ^{Day}	2004	11:20 p ^M	
	Examin		4a. Facility Name (If not institution,	give street and number,)		4b. City, Town, or	Location of	Death		4c. C	County of Dea		
			Chesapeake Hosp 5. Social Security Number		ge (In yrs. la.	st birthday)	Linth	icum If Under 24	4 Hrs. p	. Date of Birth			Arunde1	
	Funeral Director		092-30-4770	1□M 2X F	67	Yrs.	Months Days	Hours	Min.	(Month, Day MAY 19	, Year)		thplace (State or Foreign buntry) ew York	
	p >		Usual Residence of Decedent 10a. State 10b. County		10c City	Town or Lo	cation				, =-		10d. Inside City Limits	
	Aaryla f show	ō		Arundel	loo. Oity,	104110120	Crofton						1 ☐ Yes 2 No	
	r 28a-	Directo	10e. Street and Number	Arunder			10f. Zip Code	<u> </u>	 _	1	10g. Citiz	en of What Co	ountry?	
	th with	alD	1748 Laurance C	t.				21114				USA		
	tems	Funeral	11. Marital Status	12. Was Decedent Armed Forces od 1 \(\text{Yes} \) 2\(\text{A}	Ever in U.S	. 13.\	Was Decedent of H f Yes, specify Cuba	ispanic Origi ın, Mexican,	in? (Speci Puerto Ri	fy Yes or No- can, etc.)	1.	4. Race - Ame Black, Whit		
36	ours after death with the Marylar rel', or items 23a or 28a-f show Examinar must be notified at	by F	12 Never Married 2 Marrie 3 Widowed 4 Divorced	lf Yes 2∆ If Yes, Give Year or Dates:			I□Yes 21XNo	Specify:				Specify:	White	
Š	"neturel",		15. Decedent's (Specify only highest	s Education		16a. Deced	lent's Usual Occup	ation	of working		16b. Kin	d of Business	/Industry	
21	s within 72 ho ilene. r then "netur the Wed cal	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life. I	DO NOT use retired	d)	UI WUIKIII	·		_		
2	e filed within 72 hours after death with the Maryland il Hyglene. other then "neturel", or items 23a or 28a-f show vent, the Medical Examinar must be notified at	e Co	17. Father's Name (First, Middle, L	ast)		Cieri	k/Typist	18. Mother	's Name (First, Middle,		Insura:	nce	
au	be de la la la la la la la la la la la la la	To Be	George Overko						,	mielau		- ,		
Maryland 21215-0036	s 1 and 2 should f Health and Menitem 27 Is marke other treumatic	-	19a. Informant's Name/Relationshi	ip (Type, Print)		19b. Mailir	g Address (Street	and Number	or Rural I	Route Number	r, City or	Town, State, 2	Zip Code)	
	and 2 lealth m 27 I		Anne Nourse/si	ster			Laurance			on, MD				
Jore	0 0		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation				sition (Name of natory or other place ematory,		Dai 5/26/			ation - City or timore		
Baltimore,			*4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service 5	ecify)	1.		• .						, IID	
B	permit. Departr Importe eny Inj		- 21111912	icDonald	w		Cremation 299 Frede	rick F	ary o Road	nary. Balti	more	, inc.	1228	
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	nly one cause on each	od the death. line. AuG s a conseque	M	97 SANS N	g, such as ca			est,		Approximate Interval Between Onset and Death SWWWTL	
8760,	ate be executed hysicien and the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	s a conseque s a conseque									
Box 687	ath certificate attending physion use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 gronths?	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal c	death 3□	Ectopic pregnancy				23	3d. Date of dei Month	ivery Day Year	
o.	0 0 0	nyslo	1 ☐ Yes 2 No 9 ☐ Unknown	9□ Unknown	11 11110 01 000	1(I) JC	Ottlet (specify)							
rds, P	The law requires that the site has been signed by the bage 2 should be detache	by	Part II. Other significant condition	ns contributing to death	but not result	ting in the u	nderlying cause giv	en in Part I.					the cause of death?	
Vital Records,		Completed								24a. Was a autops perform	sy	prior to death?	utopsy findings available completion of cause of 2 \(\text{No} \)	
Vita	icten: certific	Be	25. Was case referred to medical examiner?	Hospital:			t 3000A Oth	ar		Check only on			Hospice	
Division of	ding Phys h. After this funeral dii	tlon; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inj (Month, D	ury 2	R/Outpatien 28b. Time of Injury	28c. Injun Worl	y at	28	5 Reside		wither (Specoccurred	city) HOSPICE	
Divisi	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely illied in by the funeral director.	Certification;	3 Suicide 6 Could n 4 Homicide determin	28e. Place of Ir building, e	njury - At hom atc. (Specify)	ne, farm, str	eet, factory, office		28	f. Location (SI City or Town		Number or Ru	ural Route Number,	
	he Hospil in 24 hour he Funere pletely fille	Medical (29a. Certifier 1 Certifying (Check only one)	Physician: To the bes xaminer: On the basis and manner s	of examination	ledge, death on and/or in	occurred at the time restigation, in my o	ne, date and pinion, death	place, an occurred	d due to the cat the time, d	ause(s) a ate and p	nd manner as blace, and due	stated. to the cause(s)	
)	To I With Com	W	29b. Signature and title of certifier	Chare w	Q.		29c. Licens	636	+	2	9d. Date	signed (Mont	n, Day, Year)	
	<i>(h</i>)		3. I me and address of person w	RATE WID	death (Item	1525	ATE RO	30D	thi	MPORIS	d	1D SI	401	
	Sta Registr		JUN 2 8 201	4.	trar's Signatu	STAN A	W.							

			For State	State of Man		artment of H	Health and Mo	, ,	2001	20201
			Registrar 1. Decedent's Name (First, Middle, Last)	+ /	00	1-1 -		2. Date of Dea		3. Time of Death
	Physici /Medio		Wilbert	Ear/	Pa	Ttersor	7	June 21	Day Year L, 2004	12:30 P ^M
	Examin		4a. Facility Name (If not institution, give s			4b. City, Town, o	or Location of Death		4c. County of Dea	
	F		Greater Baltimore 5. Social Security Number 6. Sex		Center In yrs. last birthday,	Tows	SON	8 Date of Birth	Balti	more rthplace (State or Foreign
	Funeral Director			M 2 F	53 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day)	1950 m	ARULANO
	and w.		Usual Residence of Decedent 10a. State 10b. County	1	0c. City, Town or L	ocation		-		10d. Inside City Limits
	death with the Maryland oms 23a or 28e-f show I must be notified at	tor	mo N/a		Baltimo					1 Pres 2 No
	th the or 28e	Director	10e. Street and Number			10f. Zip Code			0g. Citizen of What C	ountry?
	s 23a	ral	2603 Seamor				75		USA	
+10	fter de	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 D No	er in U.S. 13.	Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Spec an, Mexican, Puerto F	cify Yes or No- lican, etc.)	14. Race - Am Black, Wh	
336	n 72 hours after death with the Marylan "naturel", or Items 23a or 28e-f show edical Examinat must be notified at	d by	3 DWidowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		Specify: 6	<i>lack</i>
5	n 72 h "natu	lete	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of working	g	16b. Kind of Busines:	s/Industry
212	Jwithin 72 jiene. r then "nai	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	En	gineer	0)	/	Recycling	Company
nd.	be filed ital Hygi of other event, L	BeC	17. Father's Name (First, Middle, Last)	Pellon	200:-		18. Mother's Name	(First, Middle, M		
8 %	Men Men arke	ဥ	1homas	Patter.		no Address (Ctreat	Ester	/V)	clean	7: 0-4-)
Ma C	and 2 sho lealth and m 27 Is m		19a. Informant's Name/Relationship (Type)	nes - Sis	teR 491	B Bowl	and Number of Rural	Car	1.	21p Code) 1206
je 🛨	es 1 a of Hea fitem r othe		20a. Method of Disposition 1 Burial 2 Cremation 3 Re		20b. Place of Dispo	osition (Name of matory or other place	ce) Da	ite	20c. Location - City o	
OZĒ	O = = 0		'4 □ Donation S Other (Specify)	11	orraine	Park	6-28	-04 1	Voodlawi	, MD
Bal	permit. Pa Departmen Importent: any injury		21. Signature of Fun eral Service License	///		2. Name and Addre	1 -1 -	n Earlh	The Paris 1	2/229
	-		23a. Parit Enter the disease, or complice shock, or heart failure. List only on	cations that caused the				respiratory arre	Hon Pass E	Approximate
	Physician		Immediate Cause (Final disease or condition	Seps						Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a c	onsequence of):	e				
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a c		ilure				UNKNOWN
	cuted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Nen	al ma	-55				UNKnown
90,	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a c	onsequence of):					
58760,	icate b physic s the b	edical	, d							
9 xo	eath certific attending for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of p					23d. Date of de	livery
B	se death the atte	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at tim		□Ectopic pregnancy □ Other (specify)	y 		Month	Day Year
P. 0	es that the d igned by the be detached	Phy	Part II. Other significant conditions con		ot resulting in the u	nderlying cause giv	ven in Part I.	23e. Did tob	acco use contribute t	o the cause of death?
Vital Records, P.O. Box	sign sign d be	ed by								robably 4 Unknown
000	ie law requ has been je 2 shoult	Completed						24a. Was ar	24b. Were a	utopsy findings available completion of cause of
E E	ysicien: The sis certificate ha director, page	Com						perform	ned? death?	2 No
	sicien: Th certificate irector, pag	Be	25. Was case referred to medical examiner?	ospital: V.		oth Oth	26. Place of Death			
, to	ing Phys After this funeral di	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Ye	2 ER/Outpatier	" DON	4 Noising Hom		nce 6 Other (Spe winjury occurred	ocify)
sion	endin eath. or: Aft the fun	catio	1 Natural 5 Pending 2 Accident investigation	(MOIIII, Day 1	ear) Injury		Yes 2 □ No			
Division	or Att	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (- At home, farm, str Specify)	reet, factory, office	28	Bf. Location (Str City or Town	eet and Number or R , State)	ural Route Number,
	To the Hospitel or Attending Phys within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral di		29a. Certifier 1 Certifying Phys	ician: To the best of n	ny knowledge, deat	h occurred at the tin	me, date and place, ar	nd due to the ca	use(s) and manner a	s stated.
	the Ho lin 24 I the Fu	Medical	one)	er: On the basis of ex and manner stated	amination and/or in	vestigation, in my o	pinion, death occurred	d at the time, da	ite and place, and due	to the cause(s)
	To With	2	29b. Signature and title of certifier	MD		29c. Licens			d. Date signed (Mont	h, Day, Year)
	1		30. Name and address of person who col		h (Item 23a) (Tyne	Print)	07.1.78		6/2/	09
1	٧ `		KWABENA OSS	CI- BOATS	2144	1920 6	03728 ampbell	Blud	Balton	ore MD 212
	Sta Registr		31. Date filed (Month, Day, Year) JUN 2 8 200	32 Aegistrar's	4 6	and a			•	

			State of Maryland / Department of He State For State Registrer State of Maryland / Department of He Certificate of D	ealth and M	lental Hygi	iene _		20202
	Pĥysici	20	1. Decedent's Name (First, Middle, Last)		2. Date of Death	1	Year	3. Time of Death
	/Medic		Harry Felton Queen		June 24			12:29 am
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or t	Location of Death		4c. County		
	Funeral		Gilchrist Center For Hospice Towson 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year	If Under 24 Hrs.	8 Date of Birth		imor	
	Funeral Director		235–48–3688 1™ 2□ F 71 Yrs. Months Days	Hours Min.	8. Date of Birth (Month, Day, Feb. 12,	Year) 1933	West	lace (State or Foreign htry) Virginia
	and wc		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				1	0d. Inside City Limits
	d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. sther than "neturel", or Itams 23a or 28a-f show ent, the Medical Examinat must be notified at	Director	Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code		10	N= Citie (1)		1 ☐ Yes 2 No
	3a or	10	9712 Red Clover Court 2123	44	10	g. Citizen of \ U.S.A.		ntry?
	death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of His		ecify Yes or No-	14. Rac	e - Americ	
	036 ours after des el', or Itams Exs. ciret m	by Fu	1 Never Married 2 Married 1 12 Yes 2 No 1932 → If Yes, Give 10 5 4 1 Yes 2 No	Specify:	Hican, etc.)	Specify	k, White,	
	15-00:	ted k		tion	1	6b. Kind of Bu		ite
	vithin 7	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Account ant	uring most of worki				·
	d 2.	CO a	4 Accountant	18. Mother's Name		RailRoa		
	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours all Dep. fument of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or any injury or other treumatic event, the Modical Exert	To Be	Emmitt Blair Queen	Opal McK	inney			
:	Mal Nd 2 st Ith and 27 Is n	1	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Thelma Queen (Wife) 9712 Red Clove:			-		,
Aw	or Hear item		20a. Method of Disposition 20b. Place of Disposition (Name of	•		Oc. Location -		
4 6	Baltimore, Dermit. Pages 1 ar Department of Hea mportant: If item: any injury or other		'4 □ Donation 5 □ Other (Specify) Md. Veterans Cem.	June 28	3,2004 G			est, Md.
જ	Ball permit Deper Import any in		21. Signature of Funeral S C from see 22. Name and Address Bruu	of Facility Zdzinski	Funeral	Home,	P.A.	7 04 004
8		\leq	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock or heart failure. List only one cause on each line.	astern av	venue, E	ssex, r	Mary L	Approximate
0	Pnysician	2 1	shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Final Stage Condition Final Stage Condition Final Stage Condition Final Stage Condition Final Stage Condition Final Stage Condition Final Stage Condition Final Stage Condition Final Stage Condition Final Stage Condition Final Stage Condition Final Stage Condition Final Stage Condition Final Stage Condition Final Stage Condition Final Stage Final	2-1 4	ailur	'e		Interval Between Onset and Death
	/Medical Examiner		resulting in death) a	177 - 1				proving
h 0-	F IN N. A.	<u>.</u>	Immediate Cause (Final disease of condition resulting in death) a	Loma				YEARS
40-4X-04	uted d ansit	Examiner	Cause (Disease or injury					
9	9 760, ate be executed hysician and the burial-transit	Exa	that initiated events c. Due to (or as a consequence of):					
	68/6 tificate bug physic as the bu	dlcal	d					
ner!	OX 68 h certifica anding ph use as th	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d Dat	of delive	
2 5	o death e death ed for u	Physiclan/Med	in the past 12 months? 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No			Mor		Day Year
۵ د	hat the ed by the detache		9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given	n in Part I	23a Did toha	acco uso contr	ibuto to th	e cause of death?
20	COrds, P.O. BOX 68 wrequires that the death certifica been signed by the attending phe should be detached for use as the strong by the strong	ted by	and the district of the distri					abiy 4 🗆 Unknown
S	Kecord he law requir h has been si age 2 should l	Completed			24a. Was an autopsy	. p	rior to con	sy findings available apletion of cause of
	ral K	e Co	25. Was case referred to medical			No 1	eath?	2 □ No
5	OT VITAL Physicien: 1 this certifical ral director, pr	0 0	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	26. Place of Death 4 □ Nursing Hore	<i>(Check only one)</i> ne 5 ☐ Residen		r (Specify	Hospice
	ng Phys fter this	on: T	27. Manner of Deati 28a. Date of Injury 28b. Time of 28c. Injury a Work?	at 2	8d. Describe how		1.7. 37	1100/014
N N	LIVISION I or Attending after death. Director: Afte	catl	☐ Accident investigation M 1 ☐ Ye	es 2 No	10()			
	UIVI	Certification:	4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	2	8f. Location (Stre City or Town,	et and Numbe State)	r or Hural	Route Number,
	DIVISION OF VITAL HER TO THE HER TO THE HER TO THE HOUSE ALL OF THE HER THE THE SENTIFICATION OF THE COMPLETE HER THE COMPLETER HER THE COMPLETER HER THE COMPLETER HER THE COMPLETER HER THE COMPLETER HER THE THE COMPLETER HER THE THE THE THE THE THE THE THE THE THE	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, 2 Medical Examiner: On the basis of examination and/or investigation, in my opin and manner stated.	n, date and place, a nion, death occurre	nd due to the cau ed at the time, date	se(s) and mare and place, a	ner as sta nd due to	ited. the cause(s)
	To To To To To To To To To To To To To T	Σ	29b. Signature and title of certifier 29c. License r		_	I. Date signed		•
	10X,		30. Name and address of person who completed ause of death (Item 23a) (Type, Print) N. A. R. Ley CBM (6701 M. Chan	le 17	2 11	11 -1	7/2	200
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature		Jacto	1100		
	Registr	_	JUNA 8 2004 Sentra & Sporter					

			1 - For State Registrar	State of I	Marylar	-	artment rtificate			Mental Hy	/giene Reg. No		20200
	Physici /Medio		1. Decedent's Name (First, Middle, Last Mary Ell		Le			_		2. Date of D	eath	2004 ^{year}	3. Time of Death
	Examir		4a. Facility Name (If not institution, give Carroll County C	street and numbers. Seneral I	ospit	al	4b. City, To		Location of Dea tminste		4c. County of Death Carroll		
2.5	Funeral Director			x □M 2 <u>M</u> F	Age (In yrs. 61	last birthday) Yrs.	If Under 1 Months	Year Days	If Under 24 Hr Hours Mir		th ay, $Year$	Co	thplace (State or Foreign buntry) EXAS
	aryland show	_	Usual Residence of Decedent 10a. State 10b. County	-	10c. Ci	ty, Town or Lo							10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	with the M a or 28a-f be notified	Directo	Maryland Carrol 10e. Street and Number 2602 Cedarhurst D	-		Re	isters 101. Zip C	ode	n 1136		10g. Citiz	zen of What Co	ountry?
980	within 72 hours after death with the Maryland ene. than "natural", or itema 23e or 28e-f show he Madical Examiner must be notilied at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 Yes 24 If Yes, Give Year or Date	s? ∑No		Was Decede f Yes, specifi 1 Yes 2[nt of His y Cubar	panic Origin? (, Mexican, Pue	Specify Yes or Norto Rican, etc.)			erican Indian, e, etc.
Baltimore, Maryland 21215-0036	ss 1 and 2 should be filed of Health and Mental Hygi Item 27 is marked other r other traumatic event, It	Completed by	15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0·12)		or 5+)	(Give	dent's Usual kind of work DO NOT use Homema	done di retired)	tion uring most of wa	orking		nd of Business	
		To Be (17. Father's Name (First, Middle, Last) Delbert Ainswo	rth					18. Mother's Na Lois	me <i>(First, Middle</i> Edgar	, Maiden	Sumame)	
		500000	19a. Informant's Name/Relationship (T) Douglas Quayle/hu	sband		2602	Cedar	hur	nd Number or A St Drive	dural Route Numb e Reist	ersto	Town, State, 2 DWN, MD	Zip Code) 21136
			20a. Method of Disposition 1			Place of Dispo cemetery, cren tro Cre	natory or oth	er place	Înc. 6/:	Date 28/04		cation - City or Limore	
Balt	permit. Page Department of Important: If any injury or		21. Signature of Europe Dawn F. McDo	nald mul	d	C 29	remati 99 Fre	on der	Society Lck Road	of Mary	land, more,	Inc. MD 212	228
	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart lailure. List only o Immediate Cause (Final disease or condition resulting in death)	ne cause on each a. <u>R</u> S	sed the deat in line.	CUN	er the mode	ol dying	, such as cardia	c or respiratory a	rrest,	(gro	Approximate Interval Between Onset and Death
,8760,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or	as a consequence a consequence	uence of):	a hr	~it	Ser Runs	her B	id	- 3ns	\$155107
.O. Box 6	The law requires that the death certifica sie has been signed by the attending ph page 2 should be detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcon 1 Live birth 4 Pregnant 9 Unknown	2 ☐ Feta at time of d	Ideath 3	Ectopic preg				2.	3d. Date of deli Month	very Day Year
۵.	quires that n signed b uld be deta	by	Part II. Other significant conditions co	ntributing to death	but not res	ulting in the ur	nderlying cau	se giver	n in Part !.				the cause of death?
al Records,	ysician: The law requir is certificate has been si director, page 2 should I	Completed								24a. Was auto perfo 1 Yes		prior to death?	topsy findings available completion of cause of
Division of Vital	문 = 교	atlon: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 5 Pending 2 Accident investigation	1 2Inpa 28a. Date of In (Month, I		ER/Outpatien 28b. Time of Injury		Other	4 🗌 Nursing I	ath (Check only of Home 5 Resi 28d. Describe	dence 6		ify)
Divis	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined	28e. Place of building,	Injury - At ho etc. (Specif	ome, larm, stre	eet, lactory, o	office		28f. Location (. City or Tox	Street and wn, State)	Number or Ru	ral Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical	29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 ☐ Medicel Exami	sician: To the be- ner: On the basis and manner	or examina	wledge, death tion and/or inv	occurred at estigation, in	the time my opi	, date and place nion, death occ	e, and due to the urred at the time,	cause(s) a date and p	and manner as place, and due	stated. to the cause(s)
)	To the To the Complet	W	29b. Signature and title of certifier	n. Sten	slen	Ymo	29c. L	icense	o Z		4	signed (Month	• • • • • • • • • • • • • • • • • • • •
	*\		30. Name and address of person who co Charles M. Hensger		9	123a) (Type, F orial <i>E</i>		W∈	stminst	er, MD 2	21157		
	Sta Registr		31. Date liled (Month, Day, Year)	32. Regis	strar's Signa	ture							

		ŀ	1 - For Registrar	State of Maryland / Depa	artment of Health and M rtificate of Death	ental Hygiei	0001 0		
	Physici /Medi		1. Decedent's Name (First, Middle, Last) LENA A.	REGANUS			Day Year 2004 9:13 A M		
	Examir		4a. Facility Name (If not institution, give str ANNE ARUNDEL HOSPI'	ΓAL	4b. City, Town, or Location of Death ANNAPOLIS		4c. County of Death ANNE ARUNDEL CO.		
	Funeral Director		5. Social Security Number 6. Sex 1 Number 218-12-7374 Support Number 1 Numb	7. Age (In yrs. last birthday) 92 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye July 13 1			
	Maryland -f show	tor	10a. State 10b. County Md. Baltimore	Co. Baltimo			10d. Inside City Limits 1 ☐ Yes 2 ☑ No		
	h with the 3a or 28a st be noti	al Director	10e. Street and Number 2812 Illinois Ave.		10f. Zip Code 21227	10g.	Citizen of What Country?		
920	within 72 hours after death with the Maryland ene. than "natural", or Itams 23e or 28e-f show hs Medical Examinat must be notified at	by Funeral	11. Marital Status 12 1 Never Married 2 Married 3 Wildowed 4 Divorced	1 Tyes 2 TNo	Was Decedent of Hispanic Origin? (Spe if Yes, specify Cuban, Mexican, Puerto F 1 ☐ Yes 2 ☑ No Specify:	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: white		
Maryland 21215-0036	Pages 1 and 2 should be filed ient of Health and Mental Hyginnt: If Itam 27 is markad othar iry or othar traumatic event, I	Completed by	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	completed) (Give	dent's Usual Occupation kind of work done during most of workir DO NOT use retired) CCT	ng	Kind of Business/Industry		
yland		To Be (17. Father's Name (First, Middle, Last) Jess C.	Shifflett	18. Mother's Name Dorothy	(First, Middle, Maid	den Surname) Haney		
		1 3	19a. Informant's Name/Relationship (Type Arvonia D. Miller	(Daughter) 190	ng Address (Street and Number or Rura. 7 Main Ave. Pasade:	na, Md. 2			
Baltimore,			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rer 4 ☐ Donation 5 ☐ Other (Specify)	Meadowrie	dge Memorial Pk.06	/29/04 E1			
21. Signature of Funeral Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Md. 21122									
23aart1. Enter the disease, or complications that dused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, enock, or heart failure. List only one cause on each line. Physician (Medical Sease or condition resulting in death) Due to (or an a consequence of):							Approximate Interval Between Onset and Death		
8760,	Examiner sician and purial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):					
.O. Box 6	death certificate e attending phy id for use as the	Physician/Medical	d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq Yes \) Yes 2 \(\subseteq No \) 9 \(\subseteq Unknown \)		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year		
rds, P	signed d be de	by	Part II. Other significant conditions control History of Cowell	buting to death but not resulting in the u	nderlying cause given in Part I.		to use contribute to the cause of death?		
Vital Record		Completed	0 0	0		24a. Was an autopsy performed 1 Yes 2			
To impatient 2 School all Nursing Home 5 Hesidence 6 Other									
and the state of t									
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical	(Check only a Medical Examine one)	ian: To the best of my knowledge, death r: On the basis of examination and/or in and manner stated.	n occurred at the time, date and place, a vestigation, in my opinion, death occurre	nd due to the cause d at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)		
	To Tool	2	29b. Signature and title of certifier T.C. Losson	Anovan, MD	29c. License number Dood 7632		one 26, 2004		
	4			pleted cause of death (Item 23a) (Type,	2112 DUNDALK	AVE B	me 26, 2004 ALTO MD 21222		
	Sta Registi		31. Date filed (Month, Day, Year) JUN 2 8 2004	32 Registrar's Signature	Sporter				

within 24 hours a To the Funeral E

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year JUNE 20, 2004 O.C.M.E M Minte 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARGARIO A KORET 111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature 31. Date filed (Month, Day, Year) JUN 2 8 2004

State Registrar

DHMH 17 Rev 1/200:

State

Registrar

31. Date filed (Month, Day, Year)

JUN 2 8 2004

32. Redistrar's Signature

repense

			2 Hall.	partment of Health and Mental Herificate of Death	lygiene Reg. No. 20207
			Decedent's Name (First, Middle, Last)	2. Date of	Death 3. Time of Death
	Physic /Medi		George W. Robillard	June	Day Year 25, 2004 9:40 P ^M
	Exami		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
			Caton Manor	Baltimore	n/a
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Months Days Hours Min. (Month,	Day, Year) Country)
	Director		Usual Residence of Decedent	Jan 1	5, 1929 Massachusetts
	yland Nor		10a. State 10b. County 10c. City, Town or I	Location	10d. Inside City Limits
	e-f s	cto	Maryland n/a Balt	imore	1 X Yes 2 □ No
	ith tha	Funeral Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	ath w	-a	3330 Wilkens Avenue	21229	United States
	er de	nue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 	No- 14. Race - American Indian, Black, White, etc.
36	rs aft	by F	1 \(\frac{\frac{1}{N}}{N}\) Never Married 2 \(\) Married 1 \(\frac{1}{N}\) Yes 2 \(\) No If \(\frac{1}{N}\) S, Give 3 \(\) Widowed 4 \(\) Divorced Year or Dates:	1 ☐ Yes 2 No Specify:	Specify: White
21215-0036	within 72 hours after death with the Maryland ene. then "naturel", or Items 23a or 28e-1 show the Walfel Examirer must be notified at	ted		edent's Usual Occupation	16b. Kind of Business/Industry
215	hin 7.	ple	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of working DO NOT use retired)	
21	2 should be filed withir and Mental Hygiene. Ie marked other then aumatic event, Ille M.	Completed	11 0 D	pisabled	Never worked
nd	be filed tal Hygie od other	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Midd	
yla	should I	To		Madeline Leves	
Maryland	2 sh and le m			iling Address (Street and Number or Rural Route Num	
	ges 1 and 2 should be filed within 72 hours after death with tha Marylan it of Health and Mental Hygiene. If item 27 le marked other then "naturel", or Items 23a or 28e-f show or other traumatic event, the Marical Examples must be notified at		Edward Robillard - brother 3921 20a. Method of Disposition 20b. Place of Disp	Old West Falls Road, Mt	. Airy, MD 21771
סר	Pages nent of h int: If ite		1 ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crit	ematory or other place) June 28,	20c. Location - City or Town, State
Baltimore,		1	' 4 □ Donation 5 □ Other (Specify) 21. Signatur of Funeral Service Licensee	Crematory: Inc. 2004	Baltimore, MD
Ba	permit. Departr Importe any nju		1 1110 10 11 5/ 10 11/	naco	ard Funeral Mome, Inc.
	- 3		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause an each line.	4107 Wilkens Avenue, Bal	timore MD 21229 arrest, Approximate
	Pnysician		Immediate Cause (Final	A	Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a. — Que to (or as a consequence of): /		1.00
0	Examiner		PARISINGAN		5/2011
	D #	iner	Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury		
	ecuta and -trans	Examin	that initiated events C.		
8760,	be executad sician and burial-transit	al E	Due to (or as a consequence of):		
687	ate hy:	edical	d		
	eath certific attending p for use as I	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delivery
Вох	death atter	Physician/M	in the past 12 months?	☐ Ectopic pregnancy ☐ Other (specify)	Month Day Year
0	at the de by the tached	hys	9 Unknown		
S, P	res thai igned l be det	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. Did	tobacco use contribute to the cause of death?
ıd	w require baen sig should b	ed	CHRUNE OBSTRUCTIUR PU	LMUNARY DISEASE 10	Yes 2 No 3 Probably 4 Unknown
ဝင္	e law re has ba je 2 sho	Completed	BIPOLAR DISOLDER	24a. Wa	
Œ.		Com			opsy prior to completion of cause of formed? death? 2 🗷 No 1 🗆 Yes 2 🗆 No
/ita	sicien: The certificate rector, pag	Be (25. Was case referred to medical examiner?	26. Place of Death Check on	
)£	Physicien: this certific ral director,	은	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie		sidence 6 Other (Specify)
n	ding F h, After funera	lon	27. Manner of Death 1 Adatural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	how injury occurred
Sic	Attending r death, sector: After by the funer	icat	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	(24)
5	l or Attenoraliter death	ertification;	4 Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)		(Street and Number or Rural Route Number, own, State)
= :	e Hospitel 24 hours a e Funerel l letely filled	O	29a. Certifier 1 Certifying Physician: To the best of my knowledge, dear	th occurred at the time, date and place, and due to the	P (SILEG/E) and manner as stated
	To the Hospitel or Attenwithin 24 hours after deat To the Funerel Director: completely filled in by the	edical	(Check only 2 Medical Examiner: On the basis of examination and/or in and manner stated.	ivestigation, in my opinion, death occurred at the time	e, date and place, and due to the cause(s)
	To the within 2 to the formula to th	Me	29b. Signature and tille of certifier	29c. License number	29d. Date signed (Month, Day, Year)
)	1.1		Iltyma M) Alterdup boctor	D21684	6/28/04
	11/		30. Name and address of person who completed cause of death (Item 23a) (Type, CV, CYRIAC, M.D, 8021 R17C)	. Print)	140 04.22
	i			HIR UNIT, MASHORIVA, (4D 21122
	Sta Registr		31. Date filed (Month, Day, Year) JUN 2 8 2004 22. Registrar's Signature	book	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Ida Louise Scott 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Oeath 4c. County of Deeth FUnder 1 Year If Under 24 Hrs.

Months Days Houre 7. Age (In yrs. last birthday, MUND 5. Social Security Number 6. Sex 8. Oate of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) 1 M 2 XF Yrs 215-22-3925 81 08/02/1922 Virginia Usual Residence of Oecedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 ☐ No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1947 W. Mosher Street U.S.A. 21217 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🏋 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) UNKNOWN Maid Housekeeper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Fountain Parrish Martha Jane Tyler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Herd Spring Court, Owings Mills, Maryland 21

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date 20c. Location - City or Town, State Venable Scott / Son _21117 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Ceme. 06/28/2004 Owings Mills, Maryland 22. Name and Address of Facility
The 21. Signature of Funeral Service icensee The Derrick C. Jones Funeral Home Ave., Baltimore, Maryland 21215 4611 Fark Hgts. 23a. Part1. Enter the disease, or complications the cau ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on incline. Approximate Interval Between Onset and Oeath Immediate Cause (Finat disease or condition resulting in death) ir as a consequence of); ardiac a Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): econdal. Oue to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Oate of delivery 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 Pres 2 No 24a. Was an autopsy performed? 1 Yes 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Hipatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Oate of Injury (Month, Day Yeer) 28d. Describe how injury occurred 1 Matural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

/Medical Examiner I or Attanding Physician: The law requires that the death certificate be executed after death, and the this certificate has been signed by the attending physicien and in byte threat director, page 2 should be detached for use as the burlia-transit of Vital Records, P.O. Box 68760, Division filled in by To the Hospitel or within 24 hours aft To the Funeral Di completely filled in

Examiner Completed by Physician/Medical IF FEMALE: Be Certification: To 29a. Certifier

Medicai

Physician

/Medical

Examiner

Funeral

Director

or 28a-f show

Itams 23a

ò

permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; any injury or other traumatic event, the Medical Exegunds.

Physician

Directo

Completed by Funeral

Be

injury or other traumatic event, the Madical Examiner must be notified at

filed within 72 hours after death with the Maryland

State Registrar

31. Date filed (Month, Day, Year)

ame and address of person who

29b. Signature and title of certifier

10V1

32. Registrar's Signature ORIGINAL

and manner stated

pleted cause of

death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

				1- For State of Maryland / Department of Health and M Certificate of Death		0001	20200
		Physic	ian	Decedent's Name (First, Middle, Last)	2. Date of Deat	Dav Year	3. Time of Death
•		/Medi Examii Funeral	cal	FIVA Frances Sauls 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Frank In Square #6.5 Pito Rosedon P 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	June 8. Date of Birth	4c. County of Death	MOP Place (State or Foreign
		Director		294–32–5283 1 M 2 F 69 Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, 3/7/193	5 Viro	ginia
		death with the Maryland ms 23a or 28a-f show Friust be rotified at	Director	10a. State 10b. County 10c. City, Town or Location Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code	11		10d. Inside City Limits 1 ☐ Yes 2 X No
6	21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If item 271s marked other than "natural", or Items 23a or 28a-f show ampiours or other traumatic event, Ite Medical Examinational be notified at 2008.	Completed by Funeral Dir	343 Magnolia Terrace 11. Marital Status 1	ecify Yes or No- Rican, etc.)	16b. Kind of Business/Ir	can Indian, etc.
4	Maryland 21	should be filed wand Mental Hygier is marked other thumatic event, the	To Be Cor	11 Homemaker 17. Father's Name (First, Middle, Last) Hasel Coe 19a. Informant's Name/Relationship (Type, Print) Homemaker 18. Mother's Name Mattie 19b. Mailing Address (Street and Number or Rura	Garl	and	2 Codel
Sauls	Baltimore, Ma	permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau once.		Elva Louise Nuckols (Niece) 13134 Rivervan Avenue 20a. Method of Disposition 1	Middle /2004 s l Home Payenue E	River, Mar 20c. Location - City or To Baltimore, A Ssex, Maryl	yland 21220 own,State Maryland and 21221
	8760,	Physician / Medical Examiner physician up ph	dical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, Learning to trimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	mon i		Approximate Interval Between Onset and Death
	P.O. Box 68	at the death certifics by the attending pt tached for use as ti	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 September 1 Yes, outcome of pregnancy 1 September 2 Fetal death 3 Sectopic pregnancy 5 Other (specify) 9 Unknown		23d. Date of delive Month	ery Day Year
Z		w requires that i been signed by should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	acco use contribute to the	ne cause of death?
	al Reco	ician: The law re certificate has bec rector, page 2 sho	Completed		24a. Was an autopsy perform	prior to cor	psy findings available npletion of cause of 2 \(\text{No} \)
	Division of Vital Records,	uttending Physideath. death. ctor: After this title funeral di	Certification; To Be	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No	me 5 Resider 28d. Describe how	nce 6 Other (Specify w injury occurred	
	Div	ospital or Al hours after of ineral Direct y filled in by		29a. Certifying Physician: To the best of my knowledge death occurred at the time date and place a	City or Town,	(co/o) and manner as at	atad
		To the Hospital or a within 24 hours after within 24 hours after To the Funeral Directory filled in both the following the follo	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated. 29b. Signature and title of certifier 4 GOST 6	ed at the time, dat	te and place, and due to d. Date signed (Month, I	the cause(s)
		Sta	- 4	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) On Jean Are Koli Kowski 9000 Franklin 5911a 31. Date filed (Month, Day, Year) 32. Registrar's Signature	repriv	re Boltime	ore mp 21237
		Registr	ar	111N1 2 9 2004 framer & france			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hydrone.

	Certificate of Death	Reg. No 2004 20210								
Physician /Medical	1. Decedent's Name (First, Middle, Last) IRENE C. SCHULER	2. Date of Death Month Day Year JUNE 26, 2004 3. Time of Death								
Examiner	4e Facility Name (If not institution, give street and number) 4b. City, Town, or the street and number in the street and									
	SACRED HEART NURSING HOME HYATTSVIL									
^o Funeral Director	5. Social Security Number 577.60.5928 6. Sex 1 M 2XXF 7. Age (In yrs. last birthday) 98 Yrs. 1 Months Days Hours Min.	8. Date of Birth NO (Mooth, Day 997) 9. Birthplace (State or Foreig Country) PA								
arylend the show	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limit								
the Maryler 28a-f shown notified at	DC WASHINGTON	1 ☐ Yes X⊠ N								
th with t	10e. Street and Number 10f. Zip Code 20017	10g. Citizen of What Country? UNITED STATES								
permit. Peges 1 end 2 should be filed within 72 hours efter death with the Maryland Depertment of Heelth and Mental Hygiene. Depertment of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumetic event, its Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 2 Married 5 No If Yes, Specify Cuban, Mexican, Puert Year or Dates: 1 Never Married 2 Married 1 Never Married 2 Married 1 Yes 2 No Specify:	pecify Yes or No- o Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: WHITE								
i within 72 ho iene. • than "natur fra Medical	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 15. Decedent's Education (Give kind of work done during most of work done	16b. Kind of Business/Industry U.S. COAST GUARD								
be filed of other event, I	17. Father's Name (First, Middle, Last) 18. Mother's Name	ne (First, Middle, Maiden Surname)								
2 should be and Mental I is marked of aumatic eve	RICHARD CLAWSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru	uni ral Route Number, City or Town, State, Zip Code)								
end 2 selth an 27 is	RICHARD W. OVERDORFF 3378 TEMPE DR. HUNTINGTON	BEACH, CA. 92649								
Pages 1 nent of Ho int: If Iten iry or oth	20a. Method of Disposition 1 XXBurial 2 □ Cremation 3 XXBemoval from State 4 □ Donation 5 □ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) BLAIRVILLE CEMETERY	Date 20c. Location - City or Town, State unk BLAIRVILLE, PA.								
permit. P Depertme Importan any injur	21. Sign for of Funeral Service Licensee 22. Name and Address of Facility FINK FUNERAL HOME, P.A KELLY CRECORY FINK M01148 426 CRAINHWY SW GLEN B	10-								
ifficate be executed in physicien and es the bundel-trensit and fedical Examiner	Immediate Cause (Final disease or condition resulting in death) a. CARDIOPULMUNG/ Faculure Due to (or as a consequence of): HTU Due to (or as a consequence of): Due to (or as a consequence of): Cause (Disease or injury) Cause (Disease or injury)									
ath certi ittending for use e	Due to (or as e consequence of): Due to (or as e consequence of): d. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use contribute to the cause of death								
ires thet the de signed by the a d be deteched to by Physic	End Stage Serile Dementiq	1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknow								
The law require sets has been signed bego 2 should to Completed I		24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?								
		1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No								
Physician: The this certificate and director, per To Be Co	examiner?	h (Check only one)								
Z 50 5	1 Inpatient 2 EH/Outpatient 3 DOA 4 Nursing Ho	ome 5 Residence 6 Other (Specify) 28d. Describe how injury occurred								
Attending in death. Sctor: After by the fune.	1 DYNatural 5 □ Pending (Month, Dey Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No	Edd. Describe now injury occurred								
tal or Attending Pris after death. at Director: After tied in by the funera Certification;	3 ☐ Suicide 4 ☐ Homicide 5 ☐ Collid not be determined 4 ☐ Homicide 5 ☐ Collid not be determined 5 ☐ Collid not be determined 6 ☐ Collid not be determined 6 ☐ Collid not be determined 6 ☐ Collid not be determined 6 ☐ Collid not be determined 6 ☐ Collid not be determined 6 ☐ Collid not be determined 6 ☐ Collid not be determined 6 ☐ Collid not be determined 6 ☐ Collid not be determined 6 ☐ Collid not be determined 6 ☐ Collid not be determined 6 ☐ Collid not be determined 6 ☐ Collid not be determined 6 ☐ Collid not be determined 7 ☐ City or Town, State) 7 ☐ City or Town, State) 7 ☐ City or Town, State)									
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification;	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
To the company of the	29b. Signature and title of certifier 29c. License number 29c. License number	29d. Date signed (Month, Day, Year) 06 - 26 - 04								
3	30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) 5865 Chellos Chapter Hy Attschie MD 20192	20 200 31								
State Registrar	31. Date filed this pay y cearl 32. Registrar's Signature									

DHMH 16 Rev 6/95

		State of	Marylan		nent of F cate of		nd Mental Hy	rgiene Reg. No.	1, 20	211
	1. Decedent's Name (First, Middle,	Last)					2. Date of D	eath		ime of Death
Physician	Geraldine	Alice	Se	eeger			June	24, 20	Yeer 04	:15pm
/Medical Examiner	4a Facility Name (If not institution,					4b. City, Tow	n, or Location of Dea			, , ı j pııı
Adminito.	Regency Park A	ssisted L	iving			Gambr	cills	Anne	Arundel	L
eral		6. Sex	7. Age (In yrs.	Me	Under 1 Year onths Days	If Under 2 Hours	24 Hrs. 8. Date of Bi Min. (Month, D	rth ey, Yeer)	9. Birthplace (S Country)	State or Foreign
or	066-12-9988	1 □ M 2 💢 F	82	Yrs.		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Feb. 5		New Yo	_
•	Usual Residence of Decedent 10a. State 10b. County		100 C#	y, Town or Location					10d Inc	ide City Limits
leted by Funeral Director	Toa. State Tob. County		100. 01	y, rown or Location						Yes 2 □ No
Completed by Funeral Director		Arunde1		Oder				10- 02		
눔	10e. Street end Number			1	0f. Zip Code			10g. Citizen of \	what Country?	
4	506 Kingdom C			0 100 111		1113	:-0.40		States	ion
nue	11. Marital Status	Armed Fo		S. 13. Was	s, specify Cub	an, Mexican,	in? (Specify Yes or N Puerto Rican, etc.)	Blac	ce - American Ind ck, White, etc.	idii,
ΥĒ	1 Never Married 2 Marrie	If Yes, Giv	е	10	Yes 2∏ No	Specify:		Specify	y:	
b b	3 ☑ Widowed 4 □ Divorced	Year or Da	ates:	16a. Decedent	Lloual Occur	nation		16h Kind of R	White usiness/Industry	
ete	15. Decedent' (Specify only highest	grede completed)		(Give kind	ol work done IOT use retire	durina most	of working	TOD. KING OF D	usiness/industry	
Ę	Elementary/Secondary (0-12)	College (1	-4or 5+)	Cafete		•		Flomont	tary Sch	001
ပိ	12 L II 17. Father's Name (First, Middle, L	asti		Carete	IIa Mai		r's Name (First, Middle			.001
Be										
5	Timothy 19a, Informant's Name/Relationsh	Costello		10h Mailing A	ddress /Street		adys G: r or Rurel Route Numi	illiland		1
		37		1000	100			E19740		
	Timothy W. Sees	er/ Son	20b. F	506 Kin	ngdom C	court	Odenton,		City or Town, St	ate
	1 ☐ Burial 2 🂢 Cremation	3 □Removal from	State	cemetery, cremato	ry or other pla					
	4 □ Donation 5 □ Other (Sp		Wes	t Arunde				4 Odent		yland
DUC.	21. Signature of Funeral Service L	icensee		Dona Dona	Idson	Funera	1 Home & (remator	y. P.A.	
a	Juanita X	Mamao	- M009	57 1411	Annap	olis R	Road Odent	on, Mar	yland 21	113
in al	23a. Part Enter the disease, or of shoot, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)		raneopl	astic Ne	urolog		eneration	arrest,	Interv Onse	years
a		_		or as a consequen	ce of):					
dical Examin		▶ b. <u>Lu</u>	ng Canc						/	years
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		Due to (d	or es a consequen	Ce OI):				1	
dical	Cause (Disease or injury that initiated events	с	Duo to /o	or as a consequen	o of):					
ğ	resulting in death) Last		Due to (c	as a consequent	2 0 01).					
\$		d								
<u>S</u>					hina anuan ai	ion in Bort I	22h Bio	tobacco use co	ntribute to the c	euro of death?
Completed by Physician/Me	Part II. Other significant condition	us contributing to de	eath put not res	sutting in the under	iying cause gr	ven in ran I.				4 ☐ Unknown
4								Yes 2∐ No	3 L FI CURDIN	- Condidati
d b							24a. Wa	s an autopsy	24b. Were aut	
ete							per	ormed?	available complete of death?	on of cause
J d m							1757	Maria Maria	-	_
ő								Yes 2 XNo	1 🗆 Yes	X No
Be	25. Was case referred to medical examiner?	Hospital:					of Death (Check only			W.
2	1 ☐ Yes 21 No	1 10			DOA .	4 🗆 1101	rsing Home 5 Res	idence 6 70th how injury occur	rod	
Medical Certification: To	27. Manner of Death 1 Natural 5 □ Pending		th, Dey Year)	28b. Time of Injury	28c. Inju Wo	nyat ork?]Yes 2∐N		now injury occur	100	Living
Certification:	2 Accident investig	ot be	of Injury As h	ome, farm, street,				(Street and Numl	ber or Rurel Rout	e Number.
F	4 ☐ Homicide determi	286. Place	ng, etc. (Speci	fy)	, actory, onice			wn, Stete)		
ပိ	one constitution and a second		5	audadea da-st-	المساد فما فيمعون	len a determina	d place and die to		anner on atakari	
edical	(Check only 2 Medical E	xaminer: On the b	asis of examina	owieage, aeath oc ation and/or invest	gation, in my	me, date and opinion, deat	d place, and due to the th occurred at the time	date and place,	and due to the c	ause(s)
₩ed	29b. Signature and Hitle of certifier	end man	ner stated.	1	29c. Licen	se number		29d. Date signe	ed (Month, Dey, Y	'ear)
~	23D. Signature and rate of certifier	1/1	12-	/		7315	~/	To signe	20	mad
	/ persa	100				17/3	0 1	June	L3, 1	JUNT
Q	30. Name and address of person v							0.4.6.5.5		•
	Russell R. DeL				Glen B	urnie,	Maryland	21061		
State	31. Date filed (Month, Day, Year)	32. R	egistrar's Sign	ature	G					
CONTRACTOR OF THE			.477		W a					

DHMH 16 Rev 6/95

			1 - State of Maryland / Department of Health and Certificate of Death	, ,	ene . Ne. O. O. I.	20210		
			1. Decedent's Name (First, Middle, Last)	2. Date of Death	6000	3. Time of Death		
	Physici /Medio		Phyllis M. Stermer	June 25.	Day Year 2004	5:15 P M		
	Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deat		4c. County of Death	3.13		
			Edenwald Care Center Towson		Baltimore	e		
	Funeral		5. Social Security Number 6. Sex 1 M 2 F	(Month, Day, Y		place (State or Foreign ntry)		
	Director	ļ	220-09-4569 86 IIIs.	Dec.12,	1917 Ma	ryland		
	rland ow		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits		
	Man a-f sh	to	MD Baltimore Towson		1 ☐ Yes 2 🂢 No			
	or 28	Director	10e. Street and Number 10f. Zip Code	100	g. Citizen of What Cou	ntry?		
	23a				<u>Jnited</u> Stat	ces		
	tama terma	nue I	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (S	pecify Yes or No- to Rican, etc.)	14. Race - Americ Black, White,			
36	within 72 hours after death with the Maryland ene. than "natural", or Itama 23a or 28a-f show ta Mudical Exartainar must be rudified at	by Funerai	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Yes 2 ☑ No Specify: 3 ☑ Widowed 4 ☐ Divorced Year or Dates:		Specify:	White		
21215-0036	hour			16	Sb. Kind of Business/In			
15	J within 72 hours after death with the Marylan siene. Jene, r than "natural", or Itama 23a or 28a-f show the Maryleal Examinat must be notified at	Completed	(Specify only highest grade completed) (Give kind of work done during most of work done during	rking	D. KING OF DUSINGSSAIN	dustry		
21,	교 등 노력	E	4 Teacher		Education	1		
P	be filed ital Hygi d other event, I	Bec	17. Father's Name (First, Middle, Last)	ne (First, Middle, Ma	iden Sumame)			
yla		၉	Charles H. Stegman Francis		s Anton			
Maryland	d 2 should th and Mer ?7 is marke traumatic			ural Route Number, City or Town, State, Zip Code)				
a)	and deal		Mr. Jeremiah Stermer / son 626 Piccadilly Road, 20a. Method of Disposition (Name of			204		
ŏ	iges 1 at of Ha if iter or oth		1 Burial 2 Mi Cremation 3 Removal from State cemetery, crematory or other place)		C. Location - City or To			
Baltimore,	it. Partiment		• • •		Towson, Ma			
Ba	permit. Pages I Department of H Important: If ite any injury or ot once.		S. Coster 1050 York Road Tou	Json, Mary				
н			23a. Part1. Anter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arres	t,	Approximate Interval Between		
	Physician		Immediate Cause (Final disease or condition resulting in death)			Onset and Death		
	/Medical Examiner		Due to (or as a consequence of):					
		Į.	Sequentially list conditions, target leading to immediate b. Claracter Construction of the conditions	1) Pu	nunny	1041,		
Т	nsit	nin	Sequentially list conditions, framy, loading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events)	371	Į.	15400		
ć	exect n and ial-tra	Examiner	that initiated events resulting in death) Last Due to (or as a consequence of):			13 7120		
8760,	icate be executed physician and s the burial-transit	dicai						
9	ntifica ng ph as th							
Вох	eath certific attending p I for use as	an/h	23b. Was decedent pregnant in the past 12 mowns? 23c. If yes, outcome of pregnancy 1		23d. Date of delive	.,		
	ne dea the at	Physician/Me	1 ☐ Yes 2 No 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		Month	Day Year		
P.0	that the de led by the detached			23e Did tobar	cco use contribute to the	no cause of death?		
Vital Records,	gr be	d by			2 No 3 Prob			
S	w requires been si	Completed		24a. Was an	24b. Were auto	psy findings available		
Be	The larate has	E O		autopsy	d? prior to coi	npletion of cause of		
ta		a u	00.11	1 ☐ Yes 2 ☐ th Check on one	No 1 ☐ Yes	2LI N0		
Ţ	S . S	To B	Hamitals Office		e 6 ☐Other (Specify	v)		
n of			27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work?	28d. Describe how				
Sio	Attending ir death. ector: After by the funer	catio	2 Accident investigation M 1 Yes 2 No					
Division	al or Attend after death Director: / d in by the f	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town, 5	et and Number or Rura State)	I Route Number,		
	Hospital of hours at Funeral D		29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place		- (-)			
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence and manner stated.	, and due to the caus rred at the time, date	se(s) and manner as st and place, and due to	ated. the cause(s)		
	To the within 2 To the complet	Σ	29b. Signature and title of certifie 29c. License number	29d	. Date signed (Month,	Day, Year)		
•			Male Sham 12783!	8 5	UNI 12 24	, 2004		
	20	,	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	المراس المراس	30	0		
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature					
	Registr	ar	JUN 2 8 2004 Severa & Sporks					

			State of Maryland / Depa		•	-	•	
				tificate of Death		a by UUT	20213	
		*	Decedent's Name (First, Middle, Last)		2. Date of Death	1	3. Time of Death	
	Physici /Medio		Vernon L. Schaninger		June 24	, 2004 Yea	′ 10:15 P M	
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of De		
			Glen Meadows	Glen Arm		Baltimo		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 ☒ M 2□ F 1 ☒ M 2□ F	Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) 9. 8	irthplace (State or Foreign Country)	
	Director		212-07-0911 94 Yrs. Usual Residence of Decedent		UI/12/19	910	Marýland	
	nyland how		10a. State 10b. County 10c. City, Town or Loc	ation			10d. Inside City Limits	
	86-1 s	cto	MD Baltimore Glen Arm	1			1 ☐ Yes 2XXNo	
	vith th	Director	10e. Street and Number	10f. Zip Code		g. Citizen of What (
	s 23g	by Funeral	11630 Glen Arm Road #112	21057		Inited Sta		
10	d within 72 hours after death with the Maryland liene. I then "neturel", or items 23a or 28e-1 show I'le Medical Evant at must be notified at	Fun	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 0 10	Vas Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto F	Rican, etc.)		14. Race - American Indian, Black, White, etc.	
930		by	3 ★ Widowed 4 Divorced If Yes, Give 1 Widowed 4 Divorced Year or Dates:	☐ Yes 2 X No Specify:		Specify: White		
2-0		Completed	15. Decedent's Education 16a. Decede (Specify only highest grade completed) (Give k	ent's Usual Occupation kind of work done during most of workin OO NOT use retired)	70	6b. Kind of Busines	s/Industry	
121		mpi	Elementary/Secondary (0-12) College (1-4or 5+)	onoruse retired) ° Chinist	i	Western 8		
d 2	Hygie other		11 Mac 17. Father's Name (First, Middle, Last)	18. Mother's Name			TIECTLIC	
lan	be d late	To Be	Edward Peter Schaninger	Lillie		,		
Maryland 21215-0036	shou	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	g Address (Street and Number or Rura	l Route Number, e	City or Town, State,	Zip Code)	
	and 2 sealth ar m 27 is her treu) Hunter Green Roa	d, Upper	co, MD.	21155	
Baltimore,	- T 0 ~		Durial 2 Cierration 3 Chemoval nom State	sition (Name of Diatory or other place)	ate 20	Oc. Location - City of	or Town, State	
Ë	Pa nen ant		'4 □ Denation 5 □ Other (Specify) Parkwood		9/2004		le, MD.	
Bal	permit. Departr Importe any inju			Name and Address of Facility Ru 1050 York Road Tow			l Home, Inc 1204	
i	pt-		23a.Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.			•	Approximate	
	Pnysician		Immediate Cause (Final	B CARDIAC	FAIL	110 5	Interval Between Onset and Death	
	/Medical		disease or condition resulting in death) a	عدالا الله	11110	01-6	- There's	
	Examiner		Sequentially list conditions. b. TSCHEMIC	C GARDIOMY	10 PAT	ity	4 YEARS	
W.	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ARTERY	DICE	ASE	TAYEADO	
	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):	1 110121-1		11) -1-	20 11-4TIS	
760,	te be e ysician e buriż	caiE	ATHERO	SCLEROSIS			40 YEARS	
9			U.				, , , , , ,	
Вох	th cer tendin r use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ E	Ectopic pregnancy		23d. Date of de		
П	ne dea the att	sici	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		Month	Day Year	
P.O.	that the deatled by the atterdeted for		9 Unknown Part II. Other significant conditions contributing to death but not resulting in the unc	deriving cause given in Part I	23e Did toba	CCO Use contribute (to the cause of death?	
ds,	uires t signe ld be	d by	DIABRIES MELLITUS TYPE	- II	1 ☐ Yes	- 1.	Probably 4 Unknown	
Vital Records,	The law requires that the death certifica tte has been signed by the attending ph age 2 should be detached for use as th	Completed by	GOUT HYPERTENSION	5	24a. Was an	24h Were a	utopsy findings available	
Re	ii cien : The lav certificate has rector, page 2	omp	COO. P.D SPINAL ST	ENOSIS	autopsy	prior to death?	completion of cause of	
ta	ien: rtifica stor, p	Be C	25. as case referred to medical	26. Place of Death		No 1 □ Ye	s 21540	
of <	Physicien: this certific ral director,	ToE	examiner? 1 Yes Hospital: 1 Inpatient 2 ER/Outpatient	3 □ DOA Other: 4 Wursing Hom	ne 5 🗆 Residend	ce 6 □Other (Spe	ecify)	
	ding P	ion:	27. Manner of Death 1 Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	8d. Describe how	injury occurred		
Division	l or Attending after death. Director: After I in by the fune	Icat	2 Accident investigation 3 Suicide 6 Could not be	M 1 Tyes 2 No	Of Leasting (Ctr.			
Ο̈́	after Direct	Certification;	4 Homicide determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	st, factory, office	City or Town,	et and Number or R State)	tural Houle Number,	
	e Hospitel 24 hours a e Funerel [letely filled		29a. Certifier Certifying Physicien: To the best of my knowledge, death	occurred at the time, date and place, as	nd due to the caus	se(s) and manner a	s stated.	
	To the Hospitel or Attending Physicien: The I within 24 burs after death. To the Funerel Director: After this certificate hat completely filled in by the funeral director, page	edical	one) 2 medical examinar: On the basis of examination and/or inve	stigation, in my opinion, death occurre	d at the time, date	e and place, and du	e to the cause(s)	
	To the twithin 2.	Σ	29b. Signature and little of certifler	29c. License number	29d	Date signed (Mon	tyr. Day, Year)	
•	æ.		KAMANA GOPALAN	MD 15/2	-4,	01201	2007	
	10		30 Name and address of person who completed cause of death (Item 23a) (Tope, P	KOLLING XRI	5#159	BACTIM	TORP MD	
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	710	1 1 - 1		21228	
2	Registr	ar	JUN 2 8 2004 Sener & Spore	de				

			1 - State	State of M	aryland / Depa	artment of H		•	2001	20011	
	No.	**	1. Decedent's Name (First, Middle, Las	st)		Timeate of	Death	2. Date of De		3. Time of Death	
	° Physici /Medic			Frances H	E. Scherba			June 2	Day Year 21, 2004	6:42 A M	
	Examir		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, o	or Location of De		4c. County of Dea	th	
4			2203 Lincoln Ave				emere		Balti		
	Funeral Director			ex 7. Ag □M 2ਊF	ge (In yrs. last birthday) — Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi	n. (Month, Da	y, Year) Co	thplace (State or Foreign ountry)	
ı.			219-28-2674 Usual Residence of Decedent		73			April	22,1931 M	aryland	
	ryland how		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits	
	e Ma	Director	Maryland B	altimore		Edge	emere			1 ☐ Yes 2 🕅 No	
	or 24	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	ountry?	
	s 23s	rai	2203 Lincoln Av		F 110		212				
36	hours after death with the Maryland turel', or Items 23s or 28e-f show at Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give	No	was Decedent of F If Yes, specify Cuba 1 ☐ Yes 2€ No	Ispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No- erto Rican, etc.)	- 14. Race - Ame Black, Whit	e, etc.	
21215-0036	72 hours "neturel", Idical Exc		15. Decedent's Ed	Year or Dates:	16a Dece	dent's Usual Occup	ation		16b. Kind of Business	White	
15	s within 72 ho piene. r then "netur the Medical	Completed	(Specify only highest gra	de completed)	(Give	kind of work done DO NOT use retire	during most of w	rorking	160. Kind of Business	industry	
212	be filed trail Hyg ad othe event,	No.	12 Years	College (1-4or !		al Estate	e Agent		Real Es	tates	
nd		Be (17. Father's Name (First, Middle, Last)				18. Mother's N	ame (First, Middle,	Maiden Sumame)		
yla		2	John Limba					onica Ste			
Maryland	12 sho		19a. Informant's Name/Relationship (er, City or Town, State, 2 Marvland		
	it. Pages 1 and rtment of Health rtent: If item 27 njury or other tr		Mr. Charles B. 1	Nathewitch	20b. Place of Dispo	East Ave	enue be	Date Date	20c. Location - City or	21206	
пог			1 ABurial 2 ☐ Cremation 3 ☐		cemetery, crei	natory or other plac	· I				
Baltimore,			Donation 5 ☐ Other (Specify 21. Sign ure of Funeral Service Light	-	22	. Name and Addre	ss of Facility			e, Maryland	
Ba	permi Depa Impo eny ii		1) eic	Can		Duda-Rucl 7922 Wis	k Funéra se Ave.	Dundalk,	f Dundalk, Maryland	212 2 2	
			23a. Part1. Enter the disease, or com- shock, or heert failure. List only	plications that caused one cause on each li	ne.	,				Approximate Interval Between Onset and Death	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a MTHER	OSCLEK	DTIC	CARDI	0VAS64	RLAZ DISER	2SE	
	Examiner			Due to (or as	a consequence of):	er, Ea	011 - 06				
		ler	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequence of):	AL IN	12 (0) 6				
	outed id ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	CIRRH	6515 0	F Li	INER				
0	icate be executed physician and s the burial-transit		resulting in death) Last	Due to (or as	a consequence of):						
8760,	ate bé hysici the bu	dicai		JHY16	KIENS	OX					
9	death certificate be executed e attending physician and id for use as the burial-transit	Med	IF FEMALE:								
Вох	leath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnancy	,		23d. Date of deli Month	very Day Year	
o.	that the de ed by the a detached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□ Unknown	time of death 5	Other (specify) _	-				
<u>α</u>			Part II. Other significant conditions of	ontributing to death b	ut not resulting in the ur	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribute to	the cause of death?	
rds	quires n sign uld be	d by	SEITURE DI	SORDE	2			1 □ Y	es 2□No 3⊡Pro	obabiy 4 DUnknown	
Vital Records,	> 0 0	ompleted		201-20-20-2110				24a. Was a		topsy findings available	
æ	0 to	E O					-	autops perfor	med? prior to death? 2 No 1 □ Yes	completion of cause of 25 No	
ita	ysicien: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?				26. Place of De	eath (Check only or		23 110	
	S S	To 1	1 Yes 2 No	Hospital: 1 ☐ Inpatie	ent 2 ER/Outpatien	t 3□ DOA Oth	er: 4 Nursing	Home 5 🗌 Resid	ence 6 Other (Spec	eify)	
ū	ding P	ion:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Inju (Month, Day	ry 28b. Time of Injury	Wor		28d. Describe h	ow injury occurred		
Sic	Attending r death. actor: After by the fune	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	-	A	M 1	Yes 2 No	Ont Leasting (C		15	
Division of		Certification;	4 ☐ Homicide determined	building, et	ury - At home, farm, str c. <i>(Specify)</i>	eet, factory, office		City or Town	treet and Number or Ru n, State)	ral Route Number,	
	To the Hospitel or within 24 hours afte to the Funeral Dir completely filled in	aic	29a. Certifier 1X Certifying Ph	ysician: To the best	of my knowledge, death	occurred at the tin	ne, date and place	e, and due to the c	ause(s) and manner as	stated	
	ne Ho	edical	(Check only 2 Medical Examone)	niner: On the basis of and manner sta	examination and/or inv	estigation, in my o	pinion, death occ	curred at the time, d	late and place, and due	to the cause(s)	
	To the within 2 To the complet	M	29b. Signature and title of certifier			29c. License	e number	2	29d. Date signed (Month	, Day, Year)	
	1		Dounday 1	E Troll	KID	102	7188		6/21/04		
	6		30. Name and address of person who o	completed cause of d	eath (Item 23a) (Type,	Print)	0	11.	/ /		
			Stryder K	Just	eath (Item 23a) (Type, 2 Mance ar's Signature	t tlac	ce da	Honore	MD 21	1222	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	als					
			IIIN 2 8 2004	1	/ //						

State Registrar 30. Name and address

31. Date filed Mark Lay, Sea 2004

of person who completed ca

22 Registrar's Signature

use of death (Nem 23a) (Type, Print 111 Penn Street, Baltimore, Maryland 21201

			1 - For State Registrar		aryland / Dep <i>Ce</i>		lealth and M	Mental Hy	_	ible.	20216	
			Decedent's Name (First, Middle, Last)						2. Date of Death 3. Time of Death			
	Physici /Medi		Mildred M. Stottlemyer						June 24, 2004 11:35 A ^M			
	Examir		4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death									
			Gilchrist Co				owson				more	
	Funeral		,	1 M 217 F	ge (In yrs. last birthday Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	ıy, Yəar)		place (State or Foreign ntry)	
	Director		214-12-1809 Usual Residence of Decedent	Λ	82 Yrs.			AUG 25,	1921	Mar	yland	
	within 72 hours after death with the Maryland ene. than "neturel", or items 23s or 28s-f show its Madical Examiner must be notified at		10a. State 10b. County		10c. City, Town or L	ocation				1	I Od. Inside City Limits	
		ţ	Maryland Baltim	ore		C	ockeysvi	110			1 ☐ Yes 2 💢 No	
		Funeral Director	10e. Street and Number	010	10f. Zip Code				10g. Citizen of	What Cour	ntry?	
		ai	512-F Lake Vist		21030			US	A			
	ems ems	iner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp	pecify Yes or No	- 14. Rac	e - Americ ck, White,		
98	or it	F	1 XNever Married 2 ☐ Married	1 ∐Yes 2 X If Yes, Give	No	1 ☐ Yes 2 ☒ No	Specify:	r nour, oto.,	1.0	v: Whi		
9	hours urel'.	d by	3 Widowed 4 Divorced	Year or Dates:								
21215-0036	"net	Completed	15. Decedent's E (Specify only highest g	ducation rade completed)	\ (Give	dent's Usual Occup s kind of work done of DO NOT use retired	during most of work	king	16b. Kind of B		•	
12	should be filed and Mental Hygi s marked other umatic event.		Elementary/Secondary (0-12) College (1-4or 5+) 12 Management Analyst				_	Social Security				
9											lon	
lan		To Be										
Maryland		-	19a. Informant's Name/Relationship			ng Address (Street				State, Zip	Code)	
			R. Edward Decker	/Nephew	220	7 Carroll	Mill Ros	d Phoen	dv MD	21131		
J.	of Her item		20a. Method of Disposition	-	20b. Place of Disp	osition (Name of matory or other plac	e)	Date	20c. Location -			
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 ti any injury or other tre anse.	h,	1 ☐ Burial 2 🕅 Cremation 3 '4 ☐ Donation 5 ☐ Other (Spec			ematory,	4	5/04	Baltin	1000	MD	
alti	permit, Pag Department Importent: I any injury o		21. Signature of Funeral Service Lice	ensee //	- 2	2. Name and Addres	ss of Facility	C 1	4D T	ore,	,	
<u> </u>	89 = 9		21. Signature of Fungal Service Lice Fidward A 23a. Part Lice the disease, or con- shock or heart failure. Lice only	Gregorch	ik 2	remation 99 Frede	rick Ro	ty of t	ID, Inc	≥. ≥. MI	0 21228	
г			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nelications that caused y one cause on each li	d the death. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory a	rest,	- 9 111	Approximate Interval Between	
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	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):						gear	
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	sician and burial-transit	cam	Cause (Disease or injury that initiated events c. Plue to (or as a consequence of):									
8760,	cian cian curial	E		Due to (or as	a consequence of):							
87	physicate by the k	edicai		d								
Box 68	eath certific attending p	/Me	IF FEMALE: 23b. Was decedent pregnant		23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy					23d. Date of delivery		
ñ	death a atte	Physician/M	in the past 12 months?		Month Day Year							
O.	the de by the dacked tached	hysi	9 Unknown	9□ Unknown								
٥,	v requires that been signed should be de	by P							23e. Did tobacco use contribute to the cause of death?			
rds									1 Yes 2 No 3 Probably 4 Unknown			
Records,		Completed			24a. Was an 24b. Were autopsy findings available							
R	: The lay	Eo							rmed?	death?	npletion of cause of 2□ No	
Vital		0	25. Was case referred to medical 26 Place of Death Check only one									
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n of												
0	Attending in death. ector: After by the fune	catio	1 Montarial 5 Pending (Montin, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No									
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	urs af											
	To the Hospital of within 24 hours at To the Funerel D completely filled in	icai	29a. Certifier (Check only only edge) (Check only edge) (Check									
	thin 2 the mplei	Medical	one) and manner stated. 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year									
=	To To Con								Truck 2 & 200 &			
	1 %		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. A. Riley GBMC 6701 N. Charles St. Balto. MY 2:20x									
	10 1 A Dila General AN Charles St. Balto, M 2120x											
	Sta	te	31. Date filed (Month, Day, Year)		ar's Signature	-						
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crr	1		For State Registrar	State of Ma	aryland / Dep	artmen ertificat					giene Reg. No.	101	202	17
		+	1. Decedent's Name (First, Middle	, Last)						2. Date of De Month	ath	your Van	3. Time of	Death
ı	Physici /Medic		Ernest	Hiram		Somn	nerfi	e1d		June	25	2004	4 12:27	P^{M}
i.	Examin		4a. Facility Name (If not institution	•		,		Location of	of Death		4c. Co	unty of Deat		
	1	3	Johns Hopkins	- ,			timo		0411			N/Z		
	Funeral Director		5. Social Security Number 220-38-8625 Usual Residence of Decedent	6. Sex 7. Ag	e (In yrs. last birthday Yrs.	Months	Days	If Under Hours	Min.	8. Date of Bin (Month, Da Sept.	th <i>y, Year)</i> 7 1942	. 1	thplace (State of buntry) linois	or Foreign
	land ow		10a. State 10b. County		10c. City, Town or L	ocation							10d. Inside C	ity Limits
	Many I sh	to	Maryland	NA	Baltimo	re							X□Yes	2 🗆 No
	n 28g	Directo	10e. Street and Number			10f. Zip	Code				10g. Citizer	of What Co	ountry?	
	23£ c	alD	3410 Leverton	n Avenue			2122	4				U.S.A		
	r dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Deced	dent of Hi	spanic Ori	gin? (Spe	cify Yes or No Rican, etc.)	- 14.	Race - Ame Black, White		
9036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Heatth and Mental Hygiene. If item 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic evant, the Medical Exercities or list be conflict at	by	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 【 ☐ Divorced	ed 1 Tes 2 If If Yes, Give Year or Dates:	No	1 🗆 Yes				,		ecify: Wh:		
Maryland 21215-0036	within 72 h ene. than "natu	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	's Education t grade completed) College (1-4or 5	(Give	edent's Usua e kind of wo DO NOT us	al Occupa rk done d se retired	ation <i>Juring</i> mos)	t of worki	ng	16b. Kind	of Business/	Industry	
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nd	be filed tal Hygi d other evant, I	Be	17. Father's Name (First, Middle, I	.ast)						(First, Middle,	Maiden Sui	name)		
yla	should ind Men inarka umaric	<u>L</u>	Ernest	н.		rfiel							lack	
Mar	12 sho h and 7 is m traum		19a. Informant's Name/Relationsh Felicie McGurri							I Route Numbe				
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nor	Pages nent of int: If it		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (St	3 Removal from State	1				une o					,
Baltimore,	+ E # = .		21. Signature of Funeral Service	_	Bayview C					04 <u>E</u>	artim	ore, M	Marylan	d
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r	1		23a. Plant1. Enter the disease, or shock, or heart failure. List	complications that caused	the death. Do not en	ter the mod	e of dying	g, such as	cardiac c	r respiratory ar	rest,	aryrai	Approximate Interval Bet	е
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	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):									
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68	ifficate g phys as the	edle												
Вох	leath certifica attending pl	M/us	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		⊒Ectopic pr	egnancy				23d.	Date of deli-	very	
	ne death of the attenthed for u	Physiclan/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at 9□Unknown		Other (sp						Month	Day Y	'ear
P.0	ac ox	Phy	9 ☐ Unknown Part II. Other significant conditio		ut not regulting in the	and a shainman		n in Boot I		020 Did to	bassa was s		***************************************	
rds,	w requires that been signed b should be deta	ed by	Takin Ones significant condition	na contributing to death b	at not resulting in the t	andenying c	ause give	mmram.		236. Did (0	-		the cause of do obably 4 □U	inknown
Vital Record	S S S	Completed								24a. Was autop		b. Were au	topsy findings a	available
H	Th ate pag	Con								perfor		death?	2 □ No	1430 01
/ita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Manaital			0.1		of Death	(Check only of	ne)			
of	di s	To	X Yes 2 No 27, Manner of Death	Hospital: 1 Inpatie				4 🗀 190		ne 5 Resid		-	city)	
Division	ding h. After fune	Certification:	1 □Natural 5 □Pending 2 □Accident investig	ation 06-25-200	y Year) Injury	1	8c. Injury Work 1 🔲 Y	? ′es 2. [X]		18d. Describe h	Sund	ul Gno	nu roof	_
Ξ	spital or Atten ours after deat laral Diractor; filled in by the	ığı.	3 Suicide 6 ☐ Could n 4 ☐ Homicide determi		ury - At home, farm, st c. <i>(Specify)</i>		, office		2	28f. Location (S City or Tow	treet and Num, State) 32	mber or Rui	ral Route Numl	be <i>r</i> ,
	Hospital or 24 hours afte 5unaral Dir tely filled in I		200 Continu	Ph		ley			A	venue,	Baltin	nore,	Marylar	
	Hos A h Sun ely	edical	29a. Certifier 1 ☐ Certifying (Check only one) 2 ☑ Medical E	g Physician: To the best of Examiner: On the basis of and manner sta	f examination and/or in	n occurred a	in my op	e, date and inion, deat	d place, a th occurre	and due to the o ad at the time, o	ause(s) and date and plac	manner as ce, and due	stated. to the cause(s)	
	To tha Hos within 24 h To tha Fur completely	Me	29b. Signature and title of certifier	ΛΛ Λ		29c	. License	number		2	29d. Date sig	ned (Month	, Day, Year)	
)	E-SEO		* SV Av	11/				O.C.	M.E.		June 2	26, 20	04	
	رد.		30. Name and address of person v	vho completed cause of d	eath (Item 23a) (Type,		on Si	reet	. Ra	ltimore				
	Sta		31. Date filed (Month Pag Year)	004 32 Registre	ad's Signature				,	LUMINE	, rate			
	Registr	ar			W.									

				State of Maryland	/ Depa	artmen		h and N	lental Hyg	jiene	gible.	20218
	Physic /Medi		Decedent's Name (First, Middle, Last) RONALD WILLIAM	SMITH					2. Date of Dea JUNE 23	, ² 2004		3. Time of Death 2:25 A
	Exami	ner	4a. Fecility Name (If not institution, give st EASTPOINT REHAB & N				Town, or Locati TPOINT	ion of Death			ty of Death	
新	Funeral Director		=12 00 32 17 11	7. Age (In yrs. Iasi 48	<i>t birthday)</i> Yrs.	If Under Months	1 Year If Un Days Hou	der 24 Hrs. rs Min.	8. Date of Birth FEB 27	Year) 1956	9. Birth	plece (State or Fore intry) MD .
	atter death with the Maryland or Items 23a or 28a-f ahow mitter coast by modified at	Director	Usual Residence of Decedent 10a. State 10b. County MD. BALTIMOR	RE ESS								10d. Inside City Limi
	23a or 2	ai Dir	10e. Street and Number 1419 SUSSEX ROAD			10f. Zip	Code	2122		og. Citizen o U.S		ntry?
920		by Funeral	11. Marital Status 12. Married 3. Widowed 4. Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 _Yes _2\fm\No If Yes, Give \(\Lambda \) Year or Dates:		Vas Deced Yes, spec	**		ecify Yes or No- Rican, etc.)		ace - Ameri ack, White	
0-61717	within 72 hours jene. r than "natural". In Medical Ex	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)		(Give life. L	lent's Usua kind of won DO NOT us DRIV	Occupation k done during r e retired)	nost of work	ing	16b. Kind of	Business/Ir	
	should be filed nd Mental Hyg s marked othe umatic event,	To Be C	17. Father's Name (First, Middle, Last) REDFORD EDWARD SMIT				JU	NE PR	e (First, Middle, M ISCILLA	STEWAR	T	
	ges I and 2 should t of Health and Mer If item 27 is marks or other traumatic		19a. Informant's Name/Relationship (Type GLORIA BRIGHTBILL/N	IIECE	2504	GRAY	MANOR	TERRAC				Code) LAND 2122
	La it		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 3 ☐ Control of Disposition 3 ☐ Re	moval from State CHESA	etery, cren NPEAK		her place) MATORY	6/24/	/04		ILLE,	MARYLAND
Dal	Department Page Importent: any injury Once.		21. Signature of Funeral Service Licenses	JOSKX					HARLES S BALTIMO			SON, INC. D 21224
	hysician /Medical Examiner	Examiner	23a. Paint. Enter the disease, or complication shock or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Support of the conditions of any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent	ce of):	esp hud	nate	as cardiac o	failur may (Diseo	no	Approximate Interval Between Onset and Death
. DOX 00/0	e attending physicie	Physician/Medical Ex	d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Ves 2 No	Due to (or as a consequent b. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel de 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3 🗆	Ectopic pre Other (spe			1/	J.	ate of delive	ery Day Year
ecords, P.O.	s been signed by the a should be detached to	by	9 Unknown/ Part II. Other significant conditions contr	buting to death but not resultin	g in the un	derlying ca	use given in Pa	urt I.	23e. Did tob			ne cause of death?
ב ו	cate has bee	Completed							24a. Was ar autopsy perform 1 Yes 2	, !	prior to condeath?	psy findings available appletion of cause of 2 No
מי אומ	is certificate director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	spital: 1 Inpatient 2 ER/	Outpatient	3 DOA	Other		n (Check only one		ner (Snecih	4)
IO HOISIA	death. ctor: After this y the funeral di		27 Manner of Death 1 Natural 5 Pending 2 Accident investigation		o. Time of Injury		c. Injury at Work? 1 Tes 2	2	28d. Describe hor			′′
- ;	- = E	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, stre	et, factory,	office	2	28f. Location (Str. City or Town,	eet and Num State)	ber or Rura	l Route Number,
1	within 24 hours af To the Funeral D completely filled is	edical	29a. Certifier (Check only one) Certifying Physic 2 Medicel Examine	ian: To the best of my knowled r: On the basis of examination and manner stated	dge, death and/or inv	occurred at estigation, i	t the time, date n my opinion, d	and place, a leath occurre	and due to the ca ed at the time, da	use(s) and m te and place,	anner as st and due to	ated. the cause(s)
,	0/	Σ	29b. Signature and title of certifier	, hu	~>	29c.	1/15	O	29	d. Date signe	d (Month,	Day, Year)
	18		30. Name and address of person who com	lonnes, www	a) (Type, F	Print) H S	ELL	wood	AUE	BALTO	6, M	P 2122
	Sta Registr	ite ar	31. Date filed (Month, Day, Year) JUN 2 8 200	32. Registrar's Signature	B	do	2/2/	,			/	

			1 - For State Registrer	State of Maryla		artment <i>rtificate</i>				lental Hy	giene	nni.	20210
			Decedent's Name (First, Middle, Last	")			-	f	,	2. Date of D	eath	004	3. Time of Death
	Physic /Medi		Odelia				Se	ele	h	June	Day 24	Year 2004	22: 42 PM
	Exami		4a. Facility Name (If not institution, give	street and number)		4b. City, T	own, or	Location o	of Death			unty of Death	
			The Johns Hopkin	ns Hospita	b	Bal	Tim	ore	CI	Ty		N/A	
	Funeral		5. Social Security Number 6. Se	x 7. Age (In y	rs. last birthday)	If Under 1 Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi	rth	9. Birth	place (State or Foreign
	Director		Usual Residence of Decedent		5 Yrs.					11/20/	1998		MD
	/land		10a. State 10b. County	10c.	City, Town or Lo	ocation							10d. Inside City Limits
	the Marylar 28e-f show	ţō	MD N/A	A B	ALTIMORI	=							1 X Yes 2 □ No
	or 28	irec	10e. Street and Number			10f. Zip C	Code				10g. Citizen	of What Cou	intry?
	23a c	a D	3408 OLYMPIA AVE.			212	15				U.S.	Α.	
	tems	Funeral Director	11. Marital Status	12. Was Decedent Ever in Armed Forces?		Was Decede	nt of His	panic Orig	gin? (Spe	ecify Yes or No		Race - Ameri Black, White	
36	within 72 hours after death with the Maryland ene. then "neturel", or items 23a or 28e-f show the Medical Examinar must be multified at	by Fi	1 Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 📉 No If Yes, Give		1 ☐ Yes 2	-	Specify:	,	, 5,50,7		ncifu	
21215-0036	hour hour	ed	15. Decedent's Edu	Year or Dates:	162 Door	dent's Usual	0					, WI	HITE
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212	d with giene.	Eo	Elementary/Secondary (0-12)	College (1-4or 5+)	NONE		•				NONE		
	be filed tal Hygie d other event, the	Bec	17. Father's Name (First, Middle, Last)					18. Mothe	r's Name	(First, Middle			
<u>Ja</u>	should be filed withir ind Mental Hygiene. s marked other then umetic event, the Mi	70 [SHAHRAM		SELEH			GITA			SA	ARAFZDI	EΗ
Maryland	2 8 8		19a. Informant's Name/Relationship (T)							l Route Numb			Code)
	other tr			ATHER				VE. I		IMORE,	MD 212	215	
Baltimore,	Pages 1 nent of H nt: ff ite rry or ott		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ F		 Place of Dispo cemetery, crer 	sition (Name natory or oth	er place	4		ate	20c. Location	on - City or To	own, State
tim	t. Pa rtmen rtent: rjury		' 4 □ Donation 5 □ Other (Specify)		GUDATH I					/2004		ALE, N	
Bal	permit. Pages Department of importent: If it any injury or o		21. Signature of Funeral Service Licens	90						LEVINS			
			23a. Part1. Enter the disease, or compl	ications that caused the do								LLE, N	ND 21208
	Physician /Medical Examiner		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	A A	nant	- 1	Ma	-	our dide o	i rospilatory a	11 651,		Approximate Interval Between Onset and Death
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	res tha signed t be det	by	Part II. Other significant conditions cor	tributing to death but not re	esulting in the ur	nderlying cau	se given	in Part I.					ne cause of death?
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ion	불독호회	atio	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	М	. Injury a Work? 1 ∐ Ye	s 2 🗆 N			in injury out		
	tel or Attendi rs after death. ai Director: A ed in by the fu	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stre cify)	eet, factory, o	office		2	8f. Location (S City or Tox	Street and Nui m, State)	mber or Rura.	l Route Number,
	To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by	ledicai	one)	sician: To the best of my kiner: On the basis of examinand manner stated.	nowledge, death nation and/or inv	occurred at estigation, in	the time, my opin	date and ion, death	place, a	nd due to the o	cause(s) and date and place	manner as st	ated. the cause(s)
	To the within 2 To the complete	Σ	29b. Signature and title of certifier	2		29c. L	icense r	umber			29d. Date sigi	ned (Month, L	Day, Year)
	1		Ide puzi				593	95		T	June	24 2	2004
	1		30. Name and address of pers in who co		em 23a) (Type, F	Print)							
	-01		Ito Poz-Priel 31. Date filed (Month, Day, Year)	GOON WOLFE	St.	Balti	mor	e N	10	2128;	7		
H	Sta Registr		JUN 2 8 2004	32. Registrar's Sign	iature .	book	2/	jetil		2128;			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 10e per Inf. 07/02/04 dip

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM #19B PER FH G832 Certificate of Death

Reg. No. 1 | 1 1- State Registra AMEND ITEM #19B PER FH G832 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2004 JUNE 24, **Physician** SILVERMAN 3:15 A M MOLLIE /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** MONTGOMERY MONTGOMERY GENERAL HOSPITAL OLNEY | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 0 (1.20, 1.21) | 1917 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months 1 □ M 2 🔽 F 86 Yrs. PA 161-01-6531 **Director** Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filled within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
and: If item 27 is marked other than "naturel; or Items 23e or 28e-f show that it is the country or other than the natifier all any or other that melic event, Its Manded Ex. 10b. County 1 ☐ Yes 2 No Funeral Director SILVER SPRING MONTGOMERY MD 10e. Street and Number 14809 Pennfield Circle 10f. Zip Code 10g. Citizen of What Country? 114809 PENNFIELD CIRCLE #214 20906 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: WHITE Specify. þ 3 X Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+**TEACHER** EDUCATION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) **SANDLER** RASKIN BERTHA BENJAMIN 19b. Mailing Address (Street and Nurse Tourneral Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3205 WOODHOLLOW CIRCLE - CHEVY CHASE, MD 20815 BENSON SILVERMAN / Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If eny injury or once. 6/25/2004 WORKMEN CIRCLE CEM. DUNDALK, MD ¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician STROKE /Medical Due to (or as a consequence of): Examiner ATRIAL FIBRILLATION 1 YEAR Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Hospitel or Attending Physician; The law requires that the death cartificata be axecuted burial-transit Due to (or as a consequence of): Box 68760, as the t IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month ō in the past 12 months?
1 Yes 2 No Year Day 4 Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ HYPERTENSION, HYPERCHOLESTEROLAEMIA 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 **X** No 1 ☐ Yes director 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 X Inpatient Medical Certification; To 2 ER/Outpatient 3 DOA his funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred After Division 1 X Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident nours after deat 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Funerel Dir 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20053542 JUNE 24, 2004 Dr. Liture Heinz - Primei Circ 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11501 GEORGIA AVENUE #515 - WHEATON, MD 20902 31. Date filed (Month, Day, Year) 32. Registrar's Signature souls Registrar JUN 2 8 2004

			For State Registrar	•	epartment of Health and M Certificate of Death	, ,	ene LN2004 20221
			Decedent's Name (First, Middle, Last,		· · · · · · · · · · · · · · · · · · ·	2. Date of Death	3. Time of Death
	Physici /Medic	al	Catherine 4a. Facility Name (If not institution, give	Crescentia	Thanner 4b. City, Town, or Location of Death	June 26	Day Year 7:18 am 4c. County of Oeath
	Examir	er	2300 Riverview Roa		Essex		Baltimore
	Funeral		5. Social Security Number 6. Sec	7. Age (In yrs. last birth		8. Date of Birth (Month, Day,)	9. Birthplace (State or Foreign
	Director		213–16–6782	M X□F 86 Yr	s. Moritis Days Flours Mari.	10/22/1	1917 Maryland
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	or Location		10d. Inside City Limits
	Mary f sho	to	Maryland Baltimon	re Essex			1 ☐ Yes 2 X No
	h the	Director	10e. Street and Number	Lober	10f. Zip Code	100	Citizen of What Country?
	23a c		2300 Riverview Roa	nd	21221	Ţ	J. S. A.
36	72 hours after death with the Maryland neturel', or items 23a or 28e-f show dical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give → Year or Dates:	 Was Decedent of Hispanic Origin? (Spilf Yes, specify Cuban, Mexican, Puerto Yes 2	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
9	2 hour		15. Decedent's Edu	cation 16a. D	ecedent's Usual Occupation	16	White Sb. Kind of Business/Industry
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21		Соп	11	Own			Grocery Store
Maryland	e d la la la la la la la la la la la la la	Be	17. Father's Name (First, Middle, Last)	1		(First, Middle, Ma	
N S	2 2 6 6	7	William Henry 19a. Informant's Name/Relationship (Ty	Hoehn	Aailing Address (Street and Number or Rura		ary Wenger Gity or Town State Zin Godel
<u>≅</u>	nd 2 should and 27 is mare treums				00 Riverview Road E		1872
Je,	ges 1 and 2 it of Health If item 27 i		20a. Method of Disposition	20b. Place of D	Disposition (Name of	Date 20	Oc. Location - City or Town, State
Ë	Pages nent of ent: If it ury or o		tX Burial 2 ☐ Cremation 3 ☐ F 14 ☐ Donation 5 ☐ Other (Specify)		Heart of Jesus Ceme	/2004 tery Ba	altimore, Maryland
Baltimore,	permit. Pag Department Importent: I any injury c		21. Signature of Funeral Service Licens	96	22. Name and Address of Facility Bruzdzinski Funera	l Home PA	
-	Q. □ ≥ 5 0		220 Part Fotor the disease or com	Jaffiers, Sr.	1407 Old Eastern A tenter the mode of dying, such as cardiac o	venue Es	ssex, Maryland 21221
	Pnysician /Medical		shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	a	1 1 1		Interval Between Onset and Death
8760,	exacuted said into the purial-transit the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of)	:	ease	15 years
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Vita	Physician: Th rthis certificate ral director, pag	Be	25. Was case referred to medical	fospital:		(Check only one)	
of	Phys this ral dir	tlon: To	1 Yes 2 No ' 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	2 □ ER/Outp 28a. Date of Injury (Month, Day Year) 28b. Tin	ne of 28c. Injury at	me 5 XResidena 28d. Describe how	ce 6 Other (Specify) injury occurred
Division	al or Attendin s after death. Il Director: Af id in by the fui	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location <i>(Stre</i> City or Town, .	et and Number or Rural Route Number, State)
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical C	29a. Certifier (Check only one) LX Certifying Phy 2 Medical Exami	sician: To the best of my knowledge, ner: On the basis of examination and/and manner stated.	death occurred at the time, date and place, or investigation, in my opinion, death occurr	and due to the cau ed at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)
	To th within To th comp	ž	29b. Signature and title of certifier		29c. License number		. Date signed (Month, Day, Year)
•	1) Ishber		H43234	J	une 28, 2004
	N		30. Name and address of person who co	ompleted cause of death (Item 23a) (To 3509 Eyster	10.11.	re, M	ed 21224
	St. Regist		31. Date filed (Mooth, Day, Year) 31. Date filed (Mooth, Day, Year) 2004	32. Registrar's Signature	South		1

Physician Susie Vinson Susie			S S	state of Maryland / I						egible.	
Physician As Facility Name of motion Sussign Vinson			1_ State	•	•					004	20222
Susign Vinson Report and number Susign Vinson Report and number Susign	Physic	ian	Decedent's Name (First, Middle, Last)							Year	
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Physician Medical Examiner Ph	Page Tent o	1		ovar irom State			06/30	/2004 Po	rtsn	outh. V	/irginia
Physician Medical Examiner Ph	ermit. Separti nporti ny inj	đ	21. Signature of Funeral Service Licencee	110000000000000000000000000000000000000	22. Nan	ne and Address of	f FacilitThe	Derrick	C. J	ones F	/н, Р.А.
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Due to (or as a consequence of):	Dhysisian		Immediate Cause (Final	13		mode of dying, st	oci as carolac	or respiratory arre	51,		Interval Between
Sequentially list conditions, large			disease or condition resulting in death)	_ <u> </u>							
The statistic of the st	Examiner		Sequentially list conditions. b. –								
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23c. If yes, outcome oil pregnancy I clube birth 2 Feel death I clube bi	entifica ing ph e as th	Med	IF FEMALE:								
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24a. Was an autopsy findings available prior to completion of cause of death? 1	equire sen si	ted	Page rewion					1 🗆 Yes	2 🗗	No 3 ☐ Prob	ably 4 Unknown
25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 1	e law has by	mple	I he make	<u> </u>				autopsy	nd2 e	24b. Were auto	psy findings available npletion of cause of
28. Place of Death (Check only one) 28. Place of Injury at Work? 1	n: Th ficate or, pag	_	25. Was case referred to modical					1 Yes 2	No		2 No
27. Manper of Death 1	ysicia is cert	0 8	examiner?	oital: 1 Inpatient 2 ER/Oi	utpatient 3[Other		1/		Other (Specifi	v)
2 Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier (Check only) 29a. Certifier (Chec	ng Ph Iter thi			28a. Date of Injury 28b.	Time of						,,
299. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Madicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)	teath. tor: A the fu	catle	2 Accident investigation			1 🗆 Yes	2 🗆 No				
29a. Certifier 1	lor Al after of Direc	ertif		building, etc. (Specify)	arm, street, ta	actory, office		City or Town,	State)	Number or Hura	l Houte Number,
Check only 2 Madicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)	spita hours inaral y fillec	O	29a. Certifier 1 Cartifying Physici	an: To the best of my knowledge	e, death occu	irred at the time, o	date and place,	and due to the cau	ıse(s) ar	nd manner as st	ated.
one) and manner stated.	the Ho in 24 I tha Fu	Medical	(Crieck Grily 2 Madicel Examiner:	: On the basis of examination ar	nd/or investiga	ation, in my opinio	on, death occur	ed at the time, dai	e and pl	ace, and due to	the cause(s)
29c. License number 29d. Date signed (Month, Day, Year)	To I	Σ	29b. Signature and title of certifier	Swo		29c. License nu	mber	29	d. Date s	signed (Month, i	Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1	1	30. Name and address of severe into	land cause of death (trans 22-1	(Type Print)	220	735		UNC	~ ~6	12007
I M DILY MD GISMC 6701 N Charles St Ballimore Md LILOY			M DHU MO) N	Charles	SU	Balli	Wor	e Mo	d 21204
State Registrar 31. Date filed (Month, Day, Year) \$2. Registrar's Signature			31. Date filed (Month, Day, Year)	82. Registrar's Signature	1						

				For State Registrar	State of I	Maryla	•		of Health of Deat		ental Hy	giene	101.	2022	2
				1. Decedent's Name (First, Middle, La	ist)						2. Date of Do	eath Day	Year	3. Time of Death	4)
	4	Physici /Medio		Veola		E.		Wi	lliam	son	June		2009	3:30 A	М
		Examir		4a. Fecility Name (If not institution, give	e street and number	er)			wn, or Location			4c. Cour	nty of Death		
				Levindale Nurs			for a foliable of 1	Balt If Under 1	imore	er 24 Hrs.	0.000	41.	0.5:4	12	
		Funeral Director		235-42-3536	1 □ M 2 🕅 F	84	i. last birthday) Yrs.		Days Hours	Min.	8. Date of Bi (Month, D	th a <i>y, Year)</i> 5 20	9. Birthpt Count	lace (State or Fore try))ign
		pur 🔏 🖫		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	cation					10	Od. Inside City Lim	nits
		farylan show	ö											XOXYes 2 □ 1	
		ours after death with the Maryla el', or Itams 23a or 28a-f shov Examiner must be notified at	Director	MD NA 10e. Street and Number		Ба	ltimor	10f. Zip Co	ode			10g. Cilizen d	of What Count	try?	
		3a or		3817 Ridgewood	A 770			2	21215				S.A.	•	
		death ms 2	Funerai	11. Marital Status	12. Was Decede	nt Ever in I	U.S. 13.	Was Deceden	t of Hispanic C	origin? (Spe	cify Yes or N	o- 14. R	ace - America		
	ဖွ	after or Ita		1 Never Married 2 Married	Armed Force 1 ☐ Yes If Yes, Give			rres, specity 1 □ Yes 2 √2	Cuban, Mexic		rican, etc.)	Spec	lack, White, e		
1	5-0036	filed within 72 hours after death with the Maryland Hygiene. uther then "naturel", or Items 23a or 28a-f show ant, the Medical Examiner must be notified at	d by	X Widowed 4 □ Divorced	Year or Date	s:		•	•	,			BI	ack	
0	5	y within 72 hours piene "natural", r than "natural", tha Medical En	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Deced	dent's Usual C kind of work of	Decupation done during mi retired)	ost of workin	ng	16b. Kind of	Business/Ind	ustry	
10	12	withir ene. than	ᇎ	Elementary/Secondary (0-12) 10th grade	College (1-4)	or 5+)		tress				Reeds	Drug	Stores	3
-	d 2	be filed withintal Hygiene. Id other therevent, the Nevent,		17. Father's Name (First, Middle, Last			1101			her's Name	(First, Middle	, Maiden Sumi		DOLCE	
Z	Maryland	e d la	To Be	Samuel Callowa	v				Mar	y Sm:	ith				
50	ary	d 2 should th and Mer 7 is marke traumatic	-	19a. Informant's Name/Relationship (-		19b. Mailin	ng Address (S				er, City or Tow	n, State, Zip	Code)	
liamson		교문으로		Leola Johnson-	Daughte	r	51	Soshaw	k Lan	e, Wy	yoming	s. De	1 199	34	
0	altimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	_	20b.	Place of Dispo cemetery, cren	sition (Name natory or othe	of or place)	D	ate		n - City or Tov		
1	Ē	permit. Pages Department of Important: If It any injury or o		'4 □ Donation 5 □ Other (Specia			butus	Memor	ial P	ark (6/28/0	4 Arb	utus	Md	
3	Salt	permit. Departr Imports any inju		21. Signature of Funeral Service Lice	nse				Address of Fac P/H We						
7	ш	205 9 9		Mynia	13.6	Ke	43	3 00 _Wa	bash	Ave.	Balti	more		1215	
_				23a. Parit. Enter the disease, or comshock, or heart failure. List only	one cause on each	sed the dea h line.	ith. Do not ent	er the mode o	if dying, such a	is cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death	
		Physician		Immediate Cause (Finat disease or condition resulting in death)	W		onia								
		/Medical Examiner		1	Due to (or	as a conse	quence of):								
			ē	Sequentially list conditions, if any, leading to immediate	b. — Due Io (or	as a conse	quence of):						-		-
*		uted d ansit	Examiner	cause. Enter Underlying Cause (Lisease or it jusy that initiated events											
	0	be executed sician and burial-transit		resulting in death) Last	Due to (or	as a conse	quence of):								
	8760,	ate be executed physician and the burial-transit	dicai		d										
	ယ	artifica ing ph	Med	IF FEMALE:											
	Box	eath certific attending p for use as	Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcor	2 Fet	al death 3	Ectopic pregr					Date of deliver Month	y Day Year	
	0	the a	ysic	1 ☐ Yes 2 ØNo 9 ☐ Unknown	4□ Pregnani 9□ Unkn <i>ow</i> r		death 5	Other (special	<i>ty)</i>			Y			
	Vital Records, P.O.	that the de ed by the detached	/ Ph	Part II. Other significant conditions	contributing to deat	h but not re	sulting in the ur	nderlying caus	se given in Par	t I.	23e. Did	obacco use co	ntribute to the	e cause of death?	
	Sp.	uires sign	d b	End - Stage	Parker	ns	erro	Diz	erze		1 🗆	Yes 25 No	3 🗌 Proba	ably 4 Unknov	wn
	00	w requir	iete	U							24a. Was		. Were autop	sy findings availab	ble
	Re	The lar	шo			,						psy prmed? 2 2 No	prior to com death? 1 Yes 2	pletion of cause o)f
	ta	sician: 7 certificat rector, pi	a	25. Was case referred to medical					26. Pla	ce of Death	(Check only		11165 4		
19		Physici this cer al direc	To B	examiner? 1 □ Yes 2 🕱 No	Hospital: 1 ☐ Inpa	atient 2	ER/Outpatien	t 3 DOA	Other: 450	Nursing Hon	ne 5 Resi	dence 6 🗆 O	ther (Specify))	
1	n of	ding Ph J. After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of I (Month,	njury Day Year)	28b. Time of Injury	28c.	Injury at Work?			how injury occu			
	<u>i</u>	ttandir death. ctor: Al y the fu	atic	2 Accident investigatio	n			М	1 Yes 2	□No					
	Division	or A	Certification:	3 Suicide 6 Could not be determined	289. Place of	Injury - Al h etc. (Spec	nome, farm, stra ify)	eet, factory, of	ffice	2	t8f. Location (City or To	Street and Nun wn, State)	nber or Aural	Route Number,	
		spita ours naral filled		29a. Certifier 1 (Certifying P)	nysicien: To the be	st of my kn	owledge, death	оссилеd at t	he time, date a	and place, a	nd due to the	cause(s) and n	nanner as sta	ited.	- 1
		To the Hos within 24 h To the Fur completely	edical	(Check only 2 Medical Examone)	miner: On the basis and manner	s of examin	ation and/or inv	estigation, in	my opinion, de	eath occurre	ed at the time,	date and place	, and due to t	the cause(s)	
_		To the within 2 To the complet	Ň	29b. Signature and title of certifier					icense number			29d. Date sign	ed (Month, D	ay, Year)	
		1		1	an			0	5650	8		Jun	2 29	4, 200	4
		h		30. Name and address of person who Z434 W BeW 31. Date filed (Month Day Year)	completed cause of	of death (Ite	m 23a) (Type,	Print) X/	ANGRI	NG	SHAD				
		J		2434 W BeW	A De-	ictraria Ci-) De	com	ore-	100	1212	15			
		Sta Registr	-	31. Date filed (Month Day Year)	Sere	Suar S Sign	19	foork,							

04-04187 KHANNI WADDLES WHM

unpend item#23a,27,PPR MF.(833,7/21/(Yespelle and Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

"1			1 _ State	State of Maryla		artment of I rtificate of			0001	20001
		*5	Registrer 1. Decedent's Name (First, Middle, Last)			timouto or		2. Date of Dea		3. Time of Death
	Physici /Medic		Khanni	Padgett	. Wadd	lles		JUNE 2	26, 2004 Year	12:30 PM
	Examin		4a. Facility Name (If not institution, give s	reet and number)		4b. City, Town, o	or Location of Deat	h	4c. County of Dea	
10			HOWARD CO GENERAL			COLU		10 D + (B) H	HOWARD	
385	Funeral Director		5. Social Security Number 6. Sex 1□	M 35 F 7. Age (In)	rs. last birthday) Yrs.	If Under 1 Year Months Days		(Month, Day		thplace (State or Foreign
m			Usual Residence of Decedent					June	8,1953 Wa	ash,D.C.
	arylan show	_	10a. State 10b. County Maryland Howard	1	City, Town or Lo					10d. Inside City Limits
	8a-f	ecto	Maryland Howard							1 ☐ Yes 2 ☑ No
	with t	D	9215 Bellfall	Court		10f. Zip Code 21045			log. Citizen of What Co USA	ountry?
	death ms 23	Funeral Director		2. Was Decedent Ever in	n U.S. 13.		Hispanic Origin? (S	Specify Yes or No- to Rican, etc.)	14. Race - Ame	
21215-0036	2 should be filed within 72 hours atter death with the Maryland and Mental Hygiene. is marked other than "natural", or Items 23s or 28a-f show aumatic event, the Medical Exameratings to rediffed at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates:		fYes, specify Cub 1 ☐ Yes 2 1 2 No		to Rican, etc.)	Specify: B	
5-0	72 ho natur iteal	Completed	15. Decedent's Educ (Specify only highest grade	ation co <i>mpleted)</i>	16a. Dece	dent's Usual Occup	pation during most of wo	rking	16b. Kind of Business	Industry
121	within ne. han "	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)	lite.	DO NOT use retire	ed)		Own Home	
	filed v Hygie thar t	e Co	17. Father's Name (First, Middle, Last)	1	Hom	ie Make	1	me (First, Middle, I	Maiden Sumame)	
an	ld be ental ked o	To Be	Samuel Padgett	5			Susie	Pett		
Maryland	shou and M s mar	-	19a. Informant's Name/Relationship (Typ	·					, City or Town, State, a	
	and 2 Balth a n 27 i		Harold D.Waddles				all Cou	_	mbia,Md.2	
Baltimore,	permit. Pages 1 and 2 should be filled within 72 hours atter death with the Maryla Department of Heath and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Items 23s or 28a-1 show any injury or other traumatic event, the Medical Example of must be molified at once.		20a. Method of Disposition 1 □ Burial 2 12 Cremation 3 □ Re 1 □ Donation 5 □ Other (Specify)		b. Place of Dispo cemetery, crei 1etropo	natory or other pla	remator	1	20c. Location - City or 04 Alexar	
Balt	permit. Departr Imports any inj		21. Signature of Funeral Service License Robert B	Balen H	C	Name and Address Chinn Fu	neral :	Service ton Rd.	Arl.Va.	
		0	23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	cause on each line.	eath. Do not ent	er the mode of dyi	ng, such as cardia	c or respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Atherosclen	otic Cardi	ovascular	Disease			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a con-	sequence of):					
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a con-	sequence of):					0 1
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							ų.
₹°.	icate be executed physician and s the burial-transif	Еха	resulting in death) Last	Due to (or as a con-	sequence of):	*				
8760,	ate be hysici the bu	edical	d.							
	entific ding p		IF FEMALE:	c. If yes, outcome of pre	ananay					
O. Box	To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funaral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physiclan/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live birth 2 F 4 Pregnant at time of 9 Unknown	etal death 3[Ectopic pregnanc Other (specify) _	y		23d. Date of del Month	ivery Day Year
, P.O	that the	by Ph	Part II. Other significant conditions con-	ributing to death but not	resulting in the u	nderlying cause giv	ven in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
rds	quires an sigr uld be							1 □ Y€	es 2≱No 3□Pr	obably 4 Unknown
900	law requir as been s 2 should	Completed						24a. Was a	n 24b. Were au	topsy findings available completion of cause of
R	The I ate ha page	Com						perform 1 Yes 2	ned? death?	2 No
/ita	cian: ertific actor,	Be	25. Was case referred to medical examiner?			0.1		ath (Check only on	7	
of o	Physi this c	To	1 XYes 2 No H	** .	ER/Outpatier	IL 3 DOA			ence 6 Other (Spec	cify)
no	ding I h. After funer	tlon	1 Natural 5 Pending	28a. Date of Injury (Month, Day Year	28b. Time of Injury	Wo	ryat rk?]Yes 2 □No	280. Describe no	ow injury occurred	•
Division of Vital Records,	Attan deat octor:	Certification:	3 Suicide 6 Could not be	28e. Place of Injury - A	at home, farm, str				reet and Number or Ru	ıral Route Number,
Ö	al or s afte al Dire	Cert	4 Homicide determined	building, etc. (Sp	ecity)			City or Town	n, State)	
	No tha Hospital or Attanding Physician: The law Gilhin 24 hours after death. (a) the Funaral Director: After this certificate has fompletely filled in by the funeral director, page 2.	edical	29a. Certifier (Check only one) 1 □ Certifying Phys 2 ▼ Medical Examin	cian: To the best of my er: On the basis of exam and manner stated.	knowledge, deatl nination and/or in	occurred at the ti vestigation, in my	me, date and place opinion, death occu	a, and due to the caurred at the time, da	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	KA	M	29b. Signature and file of certifier	M		29c. Licens	c M E	2:	9d. Date signed (Month JUNE 27,	-
	x or		30. Name and address of person who cor	A	Item 23a) (Type,		Penn Stre	et, Balt:	imore, Mary	land 21201
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Si	gnature					
	Registr	ar	JUN 2 8 2004	May May 1	& Spe	de la				

				For State Registrar		State of	of Ma	arylan		irtment of tificate of	Health and Death	Mental H	ygiene Reg. No	200	Welliam	20005
		Physic /Medi		1. Decedent's Name WILLIAM		Last)	-					Date of D Month	Day	_	Year	3. Time of Death
		Examir		4a. Facility Name (I. STELLA MO			ımber)			4b. City, Town, BALTIM	or Location of Dea	ath O	4c.	County of N/A		
		Funeral Director		5. Social Security N 213 05 80	23	.Sex 1⋤M 2□F	7. Age		ast birthday) 7 Yrs.	If Under 1 Year Months Days			irth Day, Year) 2, 19	17	9. Birthpl VIRG	lace (State or Foreign INIA
		show ed at		Usual Residence of 10a. State	Decedent 10b, County			10c. City	, Town or Lo	cation					1	0d. Inside City Limits
		he Mar 28e-1 sl	ector	MD	N/A			BALT	IMORE							1X Yes 2 No
		h with t	P Dir	10e. Street and Nut 1813 NORT		NE STRE	ET			10f. Zip Code 21213			U.S.	izen of Wh A	at Coun	itry?
	(0	filed within 72 hours after death with the Maryland Hygiene. ther than "neturel", or Items 23a or 28e-1 show ther, the Medical Expaning must be notified at	Funeral Director	11. Marital Status	ied 2 Married	12. Was Dec Armed F	orces? 2.ZN	er in U.S	1		Hispanic Origin? (ban, Mexican, Pue	Specify Yes or N rto Rican, etc.)	10-	14. Race Black,	America White, e	
2	5-0036	hours a	by	3 XWidowed		If Yes, G Year or I	ive			☐ Yes 2 🖾 No				Specify:	BLA	
Waller	215-	d within 72 hours giene. or then "neturel", I'lle Medical Exc	Completed			Education grade completed) College (+)	16a. Deced (Give life. L	ent's Usual Occu kind of work done 20 NOT use retire	pation a during most of wo ad)	orking	16b. Ki	nd of Busi	ness/Ind	dustry
5	2	filed withi Hygiene. other than		Elementary/Seco 12th			1-401 34		ADVERT	ISING SA		(F)				RO AMERICA
	lanc	2 should be fi and Mental H Is marked of eumatic ever	To Be	17. Father's Name (WILLIAM L							SUSIE C	ime (First, Midd) URTIS	e, Maiden	Sumame)		
William	Maryland	d 2 should be filed withir th and Mental Hygiene. 7 Is marked other than treumatic event, The M		19a. Informant's Na							t and Number or F		-			
116		1 an Healt em 2 ther		CLIFTON W. 20a. Method of Disp		SON)		20b. PI	3145 ace of Dispos	JEFFLANI sition (Name of satory or other pla	D RD. BAL	TIMORE,		LAND cation - C		
0	Baltimore,	Pages nent of I ant: If it ury or o			□Cremation 3 5 □Other (Spe	☐Removat from cify)	State	1		atory or other pla EM PARK		1. 200				MARYLAND
2,	Balt	permit. Page Department of Important: If any injury or ance.		21. Sign ture of Fu	neral Service Lic	ensee	Z.,			Name and Addr	ess of Facility	CALVIN I	B. SC	RUGGS	5 FUI	NERAL HOME
		- 1		23a. Part1. Enter the shock, or hea	he disease, or co	emplications that	caused	e death			RESTON ST ing, such as cardia			RE, N		Approximate
		Pnysician	6 0	Immediate Cause (disease or conditio	(Final	a.	Bacil illi	0.	blad	ider c	unie					Interval Between Onset and Death
	1	/Medical Examiner		resulting in death)	1	Due to	(or as a	consequ								
FX	1	D #	iner	Sequentially list con if any, leading to im cause. Enter Unde	nditions, nmediate orlying	b. Due to	(or as a	consequ	ence of):							
2		xecute n and al-trans	Examiner	Cause (Disease or that initiated events resulting in death) L	suler.	c	(or as a	consequ	ence of):							
4	68760,	flicate be executed physician and is the burial-transit	edical E			d										
9	39 xo	= 0.0	/Med	IF FEMALE:		23c. If yes, ou	tcome c	of pregnar	ncv					and Dave	4.4-11	
3)	. Bo	The law requires that the death cert tte has been signed by the attending page 2 should be detached for use	Physician/M	23b. Was decedent in the past 12 1 ☐ Yes 2 ☐	months?	1 ☐ Live I	birth 2 nant at t	2 Fetal time of de	death 3	Ectopic pregnand Other (specify)	:у		2	3d. Date of Month		ry Day Year
	P.0	that the de ted by the a detached f	Phys	9 ☐ Unknown Part II. Other signif				t not resu	lting in the un	deriving cause of	ven in Part I	23a Did	tobacco us	se contribu	ute to the	e cause of death?
-	rds,	w requires to been signed should be	ed by										Yes 2			
have	ecord	faw rei as bee 2 sho	Completed									24a. Was	s an	24b. We	re autop	sy findings available apletion of cause of
e)	al B			05 14/22 222 22/22								perf 1 🗆 Yes	ormed2 2 No	dea	ath?	2 □ No
35	f Vital	Physicien: "this certificaral director, p	To Be	25. Was case reference examiner?	_	Hospital:	Inpatien	nt 2 🗆 E	ER/Outpatient	3□ DOA Ot		ath <i>Check onl</i> Home 5□Res		Other	(Specify)	horice.
3	on of	fter		27. Manner of Death 1 Natural	5 Pending	28a. Date (Mon	of Injury th, Day	Year)	28b. Time of Injury	28c. Inju	ry at rk?	28d. Describe				The spice
3	Division	Hospital or Attending 44 hours after death. Funerel Director: After tely filled in by the funer	Certification:	2 Accident 3 Suicide 4 Homicide	investigat 6 Could not determine	be 28e. Place	of Inju	ry - At hor	me, farm, stre	M 1 cet, factory, office]Yes 2□No				or Rural	Route Number,
()	Ö	oltal or urs afte rel Dir lled in						. (Specify,				N.	wn, State)			
		To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fi	edicai	29a. Certifier (Check only one)	1 ☑ Certifying I 2 ☐ Medical Ex	Physician: To the aminer: On the b and man	asis of	examinati	vledge, death ion and/or inv	occurred at the ti estigation, in my	ime, date and plac opinion, death occ	e, and due to the urred at the time	cause(s) ; , date and	and mann place, and	er as sta I due to I	ited. the ca <i>u</i> se(s)
		To the within 2 To the complex	Me	29b. Signature and	title of certifier	^				29c. Licen	se number		29d. Date	signed (/	1	* '
		a		30 Nome === = ::)W 1h-	2 ~	2001 -	ath /lt	22-1/7	DH	0854		6	125	120	ר סכ
		2		30. Name and addre	dir	Riseho	SN C		23a) (Type, F	PAUL	PL Ba	Himor	e m	rd.	212	-07
		Sta Registr		31. Date filed (Mont	2°8°200	4 Sen	Registra	r's Signati	ure d	park	,					

04-0 crn	14093		1 - For AMEND State AMEND Registrar	UTEM 20	OB STATE OF	h <mark>y</mark> es	32,06P2	ertifica	g of H	ealth a	and M	fental Hy	giene	004	202	26
	Physici		Decedent's Name (if TROY A. WH		est)			<u> </u>	0, 1	Journ		2. Date of Do Month June		Year 2004	3. Time o	
	/Medio Examin		4a. Facility Name (If no		re street and num				Town, or	Location ore	of Death		4c. C	ounty of Death	1	
	Funeral Director		5. Social Security Num 217 98 694	14	Sex 1 M 2 ☐ F	7. Age (li	n yrs. last birtho 22 Yrs	Months	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi	7 , 19	9. Birth Con MARY	place (State intry) LAND	or Foreign
	Maryland f show	tor	Usual Residence of De 10a. State 1 MD	0b. County	·	Ì	Dc. City, Town o								10d. Inside C	City Limits
	death with the Maryland ms 23a or 28a-f show r nast be notified at	I Director	10e. Street and Number 1620 E. MC		STREET				p Code 205		<u> </u>		10g. Citize	on of What Co	untry?	
98	ges 1 and 2 should be filed within 72 hours after death with the Marylar at of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23s or 28s-1 show or other traumatic avent, It a Marical Examiner must be notified at	y Funeral	11. Marital Status 1 X Never Married		12. Was Dece Armed For 1 Tes If Yes, Giv	rces? 2 No	r in U.S.	3. Was Dece	ecify Cuba	spanic Ori n, Mexical Specify:	n, Puerto	ecrfy Yes or N Rican, etc.)		A. Race - Amer Black, White	, etc.	
Maryland 21215-0036	2 should be filed within 72 hours after and Mental Hygiene. Is marked other than "natural", or Ite reumatic event, It e Medical Evantine	Completed by	(Specify	5. Decedent's E only highest gr	ducation ade completed)	ates: 	16a. De	ecedent's Usu ive kind of w e. DO NOT i	ial Occupa ork done d use retired	ation during mos	st of work	ing		d of Business/l	ndustry	
nd 212	e filed with at Hygiene. I othar thar vant, Ite I	Be Com	9th 17. Father's Name (Fi		College (1	-4or 5+)		SH THRO				e (First, Middle	1	EYS EN	ERPRIS	SES
larylar	2 should be and Mente Is marked sumatic a	ToE	WALTER A. 19a. Informant's Nam	e/Relationship				-	s (Street a	and Numbe	er or Rur		er, City or	Town, State, Z		
	ges 1 and 2 it of Health a If item 27 I or other tre		EVELYN P. 20a. Method of Dispos Burial 2 0	sition Cremation 3 [Removal from S	State 🗼	20b. Place of Dicemetery,	sposition (Na crematory or	me of	e) J1	ULY !	3,2004	20c. Loca	MARYLA ation - City or 1	own, State	205
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot		' 4 □ Donation 5			1	LORRAIN	22. Name a		s of Facili	ity CZ	ALVIN B	. SCR	TO, MAF UGGS FU RE, MAF	NERAL	
	Pnysician		23a. Part1. Enter the shock, or heart f Immediate Cause (Fir			no.		enter the mo	de of dying	g, such as				KE, MAR	Approximat Interval Bet Onset and	te tween
MI	/Medical Examiner		disease or condition resulting in death)	[itions			on equence of):	OT WO	in as							
	ecuted and transit	Examiner	Sequentially list condiff any, leading to immicause. Enter Underly Cause (Disease or injustat initiated events resulting in death) Las		Due to (onsequence of):									
38760,	rcate be executed physician and s the burial-transit	dicai		l	_ d.	01 43 4 01	Sitsequence of).									
P.O. Box 6	The law requires that the death certificate that has been signed by the attending physoage 2 should be detached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent p in the past 12 me 1 Yes 2 N 9 Unknown	onths?		irth 2 🗀 ant at tim	pregnancy Fetal death e of death	3 □Ectopic p 5 □ Other (s					23	d. Date of deliv	*	Year
rds, P	v requires that the deben signed by the should be detached	by	Part II. Other significa	ant conditions	contributing to de	eath but n	ot resulting in th	e underlying	cause give	en in Part I	l. 	23e. Did	_	contribute to		death? Unknown
I Reco		Completed										24a Was auto perf	an psy ormed? 2 \(\text{No} \)	24b. Were aut prior to co death? 1 Ares	opsy findings ompletion of c 2 \bigsi No	available ause of
Division of Vital Records,	ng Phy Iter this neral d	ion: To Be	25. Was case referred exeminer? 1 Yes 2 No. 27. Manner of Death 1 Natural	5 Pending	28a. Date of (Mont			e of ry	28c. Injury Work	at	ursing Ho	th (Check only time 5 □ Res 28d. Describe Subject	idence 6 how injury	1	fy)	
Division	To the Hospital or Attanding I within 24 hours after death. To the Funeral Director: Atter completely filled in by the funer	Certification;	2 Accident 3 Suicide 4 Homicide	investigation 6 Could not to determined	-VIE 4	of injurying, etc. (5	4 5:43 - At home, farm Specify)	street, facto		∕es 2 √ Z		28f. Location (Street and	Number or Rui		
	the Hospit the Funera	edical	(Check only 2.	Medical Exa	hysician: To the miner: On the ba and mann	asis of ex	amination and/o	r investigation	n, in my op	oinion, dea	nd place, ath occurr	and due to the red at the time,	date and p	lace, and due	to the cause(s	6)
	To To Com	Σ	29b. Signature and titl	le of certifier	freed	sec	e red		c. License	o number	i.E.			22 , 20		
	B		30. Name and address TaSha 31. Date filed (Month,	Z Gre	completed caus	LM.	(Item 23a) (Ty	111 Pe		treet	, Ba	ltimore	e, Mai	yland	21201	
	Sta Registi			2 8 200	4 50	by star S	Signature	doa	de							

			1 - For Stete Registrar		of Marylar	•		t of H	eaith a		-	giene	1001	21	1227
	Physicia /Medic	al	1. Decedent's Name (First, Middle William	L.			V V V	10-01	end		2. Date of De Month JUNE	16	200	94 5	Time of Death
	Examin Funeral Director	er	4a. Facility Name (If not institution The Johns Hopk 5. Social Security Number 218-28-9242		oital 7. Age (In yrs. 7		Balt	imo	If Under 2 Hours		8. Date of Bir (Month, Di 07/08/	rth av. Year)	. County of E		State or Foreign
	0	ctor	Usual Residence of Decedent 10a. State 10b. County MD Prince	George's		ity, Town or Lo	ocation							10d. In	side City Limits ☐ Yes 2 ☐ No
	23e or 28	Funeral Director	10e. Street and Number 400 Montgomery					707				U.	S.A.		
3	urs affer des ai', or items Exercite Cro	۵	11. Marital Status 1 Never Married 2 Marria 3 Widowed 4 Divorced	Armed F	2 □ No iive	i i	Was Deced If Yes, spec			jin? (Spe Puerto	cify Yes or No Rican, etc.)	0-	14. Race - A Black, V Specify:	Vhite, etc.	dian,
	permit. Pages 1 and 2 should be filed within 72 hours after death with rine maryland Department of Health and Mential Hygiene. Department of the may 18 marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Exertities or existing a songe.	Completed	15. Deceden (Specify only highe Elementary/Secondary (0-12) 12		(1-4or 5+)	(Give	dent's Usua kind of wo. DO NOT us	rk done d se retired)	uring most	of worki	ng		ind of Busing Ster-In Compa	mus-Pe	
	nould be filed I Mental Hyg narked other natic event,	To Be C	17. Father's Name (First, Middle, William L. Wh	itehead		10h Maril	an Addroon		Do1	lie	Grey			to Tin Code	
	s 1 and 2 sr if Health and item 27 Is n other traun		19a. Informant's Name/Relations Muriel Whitehe 20a. Method of Disposition	ad / Wife	20b.		lontgo	mery	Stre	et,	/ Route Numb Laurel Pate	, Ma		d 2070	7
Dalumore,	ermit. Page Separtment o nportent: If ny injury or ince.		1 Burial 2 Cremation 4 Donation 5 Other (S	pecify) Licensee	Bal	lt-Wash	ningto 2. Name an	on Cr	em. 0	' F]	3/2004 Leck Fu	nera		e, Inc	2.
İ	nysician /Medical		23a. Part1. Enter the disease, of shock, or heart lature. List tmmediate Cause (Final disease or condition resulting in death)	_a. met	astati	ith. Do not en	ter the mod	le of dying	u, such as o	cardiac o			Mary.	Appr	oximate val Between et and Death
,000	le be executed xx ysician and le burial-transit and	Ilcal Examiner	Sequentially list con flicins, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Wide to Due to	o (or as a conse le COM o (or as a conse t Mun 5: o (or as a conse	quence of):	tac		card to		or			Ten	days years
	The law requires that the death certifica tite has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live	utcome of pregr birth 2 Fet gnant at time of nown	al death 3[⊒Ectopic pr ⊒ Other <i>(sp</i>						23d. Date of Month	delivery Day	Year
62	w requires that is been signed by should be deta	Ď	Part II. Other significant conditi	ons contributing to	death but not re	sulting in the u	ınderlying c	ause give	n in Part I.				_		se of death?
	: The taw recate has bee page 2 sho	Completed									24a. Was auto perfe 1 🗆 Yes	psy ormed?	prior	to completi h?	ndings available on of cause of No
7	Physicien: The this certificate ral director, pag	o Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☒ No	Hospital:	Inpatient 2	☐ ER/Outpatie	nt 3 DC	Othe	-		ne 5 ☐ Resi		6 DOther (Specifu)	
5	After une	atlon: To	27. Manner of Death 1 Natural 5 Pending 2 Accident invest	28a. Date (Mo	e of Injury nth, Day Year)	28b. Time o	-	28c. Injury Work	at		28d. Describe			эрөспу)	
	i i i i i i	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detem	ined 200. Flat	ce of Injury - At I ding, etc. (Spec	home, farm, st ify)	reet, factory	y, office			28f. Location (City or To			r Rural Rou	te Number,
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	edical	(Check only 2 Medical one)				rvestigation	, in my op	oinion, death			, date an	d place, and	due to the o	
	To the within 2 To the complex	Σ	29b. Signature and title of certifie		10.		-	c. License					te signed (M		
0	+1		30. Name and address of person	A Muss who completed ca	use of death (Ite	om 23a) (Type	, Print)	E5-	000]	Jun	e 26	20	04
2	Sta Regist	ate	30. Name and address of person Meli S5a Munse U 31. Date filed (Month Day Year	The Johns H	opkins Ho Registrar's Sign	ortal, 601	North W	isite Sm	et, Ba	lamo	rc, Mary	land	2128	37	

			1 - For State Registrar	State o	of Maryla	nd / Depa <i>Cei</i>	artmen rtificat	it of H e of L	ealth a Death	and M	lental Hy	gie Reg.		L	20228
	Physici	an	1. Decedent's Name (First, Middle, Las	r)							2. Date of De _Month		Day \	/ear	3. Time of Death
	/Medic		Estelle White								June 2	23,			8:00 PM
	Examir	er	4a. Facility Name (If not institution, give 6212 Burgess Aver		mber)			Town, or altin	Location o	f Death			4c. County of		
	Euparal		5. Social Security Number 6. Se		7. Age (In yrs	. last birthday)	If Under		If Under 2	24 Hrs.	8. Date of Bi	rth		A. Birtho	place (State or Foreign
	Funeral Director			☐M 2(2 \$F	78	Yrs.	Months	Days	Hours	Min.	(Month, Di 2/25/1	92	6 (ar)	Cour	yland
	pu 🖈		Usual Residence of Decedent 10a. State 10b. County		10a C	ity, Town or Lo									
	Aaryla Fahov	ō	MD N/A			6212 Bu		s Ave	nue						10d. Inside City Limits 1- Yes 2 No
	28a-1	Director	10e. Street and Number			0212 00	101. Zip		ilue			100	Citizen of Wh	at Cour	
	3a or	Ö	6212 Burgess Ave	nue				2121	4				U.S.A.		,
	within 72 hours after death with the Maryland ene. than "natural", or Iteme 23e or 28e-f ahow he Medical Examinar must be notified a	Funeral	11. Marital Status		edent Ever in t	J.S. 13.	Was Deced	dent of His	spanic Orig	jin? (Spe	city Yes or No Rican, etc.)	o-	14. Race		
36	or Its	y Fu	1 ☐ Never Married 2K Married		2 🔀 No	1	l □ Yes	_	Specify:	, Fueno 1	nicari, etc.)		Specify:	White,	
Ö	hours tural'	ed by	3 Widowed 4 Divorced	Year or D	ates:	16a, Deced						4.01			
5	in 72 n "na redic	Completed	15. Decedent's Edi (Specify only highest grad	ie completed)		(Give		rk done d	urina most	of workii	ng	160	. Kind of Busi	ness/ind	Justry
212	filed with Hygiene. other than	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Cler	ical	offi	ce wo	ork		K	oppers	Met	al Products
2	al Hyg	Be C	17. Father's Name (First, Middle, Last)									, Maio	den Sumame)		
yla	should be ind Mental I	To	James Roach						Mar	rie W	Vard				
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other than "natural", or Iteme 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at		19a. Informant's Name/Relationship (T)										ty or Town, St		
	1 and Health em 2		Lynette Weisgerbe	er	20b.					-	C Balt		Maryla Location - Ci		
nor	Pages nent of int: If it iry or o		1 Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,			Place of Dispo cemetery, cren rdens o)		3/04				Maryland
Baltimore,	그 든 뿐 중		21. Signature of Funeral Service Licens		Jou				s of Facility						HomeInc.
ä	Deparent Deparent Impo		Juchus Total	mani	111	1 5716	415 I	Belai	r Roa	ad Ba	altimor	е,	Maryla	ind	21206
5%			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that one cause on e	aused the dea	th. Do not ente	er the mod	e of dying	, such as o	ardiac o	r respiratory a	rrest,			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. C	ARI	IAC	A	R	10 to	7					Onset and Death
39	/Medical Examiner		resulting in death)	Due to	(or as a conse		014	- n	1		/				1 - 2/2 -
, t		ē	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a conse	M C 7	Clt	=0(0	OTIC		(EAI				1 OYEAR
	uted J ansit	min	Cause. Enter Underlying Cause (Disease or injury		(5. 25 2 55.155	455.100 0.7.				0	リルモメ	SZ			
ó	exection and and rial-tra	Examin	that initiated events resulting in death) Last	Due to	(or as a conse	quence of):									
8760,	cate be executed physician and the burial-transit	dlcal	(d											
9		Med	IF FEMALE:												
Box	it the death certifi by the attending tached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 mopths?	1☐Live b	come of pregn pirth 2 Fet	al death 3□	Ectopic pr						23d. Date of Month		ny Day Year
o.	the de	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unkn	nant at time of o	death 5∟	Other (sp	өспу)							·
a,	The law requires that the te has been signed by the bage 2 should be detached.	by Ph	Part II. Other significant conditions co	ntributing to de	eath but not re	sulting in the un	derlying ca	ause givei	n in Part I.		23e. Did t	obaco	o use contribu	ite to th	e cause of death?
Vital Records,	w requires that been signed b should be deta										10	Yes	2 DNo 3[] Proba	ably 4 □Unknown
ပ္သ	aw re	Completed									24a. Was		24b. Wei	re autop	osy findings available
ř	The lav	E OC										osy irmed 2 🛂	?/ dea	r to con th? Yes	npletion of cause of 2□ No
Ξ	ysician: The	Be	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o				
	Physician: r this certific ral director,	은	1 □ Yes 2 ☑ No			ER/Outpatient			4 LI NUI:	sing Horr	ne 5 Desid	dence	6 □Other (Specify)
2	ding F h. After funer	lon	27. Mann of Death 1 Matural 5 ☐ Pending	28a. Date	th, Day Year)	28b. Time of Injury	M 2	8c. Injury Work	?		8d. Describe I	now in	jury occurred		
Division of	after death. Director: A	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place	of Injury - At h	iome, farm, stre			es 2⊡N	-	8f Location (Street	and Number	or Rural	Route Number,
2	al or /	Certification:	4 Homicide	buildi	ng, etc. (<i>Speci</i>	fy)	,,	,			City or Tov	vn, St	ate)		110010 110111001,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.		29a. Certifier 1 Certifying Phy	sician: To the	best of my kn	owledge, death	occurred a	at the time	, date and	place, a	nd due to the	cause	(s) and manne	er as sta	ated.
	To the H within 24 To the F complete	Medical	one)	and mani	ner stated.	ation and/or inv				occurre					
	To the within To the compl	2	29b. Signature and title of certifier	0	P		1	. License					Date signed (A	1	lay, Year)
	\sim		20.00	سياب				DE	572	80)	L	06/2	4/0	2004
	1.2		30. Name and address of person who co	-	or death (Ite	m 23a) (Type, I	rint) 5	100	Loc	んた	Paven	11:	Blow	11	
	Sta	te	31. Date filed (Month, Day, Year)		egistrar's Sign.	ature	B	alt	imn	k,	Mary	la	nd 2	-12	39
	Registr	ar	MODE & CALL	Ben	and a	10 1	work	21			0				/

Please '	Type or	Print in	Black	Indelible Ink.	Ensure .	All Copies	Are Legible.
						•	-

304			1 - State Registrar	State of Mar	•	epartment of Certificate o		d Mental Hy		04	20229
8	Physic	an	Decedent's Name (First, Middle, Last)					2. Date of De Month	Day	Yeer	3. Time of Death
	/Medi	cal	Constanc 4a. Fecility Name (If not institution, give str		Zah		, or Location of D	June 3	25, 2004		8:30 A M
+	Exami	ier	Oak Crest	,			kville			Balti	imore
5/64	Funeral Director		5. Social Security Number 6. Sex 138-18-8088	7. Age	(In yrs. last birth	Months Day		Min. (Month. D.	rth ay, Yeer) 19,1923	9. Birthp Coun New	lace (State or Foreign http) Jersey
N	land bw		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				1	0d. Inside City Limits
9	Maryland a-f ehow	ctor	Maryland Baltimore	2	Par	^kville					1 ☐ Yes 2 💢 No
- 1	death with the ms 23s or 28s	Directo	10e. Street and Number			10f. Zip Code			10g. Citizen of		itry?
H	leath v	Funeral	8800 Walther Blvc	. Was Decedent Ev	er in U.S.		234 f Hispanic Origin	? (Specify Yes or N		S.A.	an Indian,
AHNER	<u>a</u> ₽ 8	by	1 Never Married 2 Married 3 XWidowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify Co		u erto Rican, etc.)	Bla Specia	ick, White, fy: W	_{etc.} Ihite
ZAHIN	72 ho	eted	15. Decedent's Educa (Specify only highest grade of	tion completed)	16a. C	Decedent's Usual Occ Give kind of work dor ife. DO NOT use reti	upation e during most of	working	16b. Kind of B	lusiness/Inc	ustry
	d within giene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+))	ne. Do Notuse reli Homemaker	гөа)		Own	Home	<u> </u>
	al Hyg	BeC	17. Father's Name (First, Middle, Last)					Name (First, Middle	e, Maiden Sumai	me)	
2	Marylairu nd 2 should be file tith and Mental Hy 27 is marked oth traumatic event	ို	Michael Howl		19h.)	Mailing Address (Stre		arcella or Bural Boute Numb	Bellam		Codel
E:	nd 2 si aith an 27 is i		Michael E. Zahne			Ballybunio		Timonium			21093
NATISMO	DESILITION CE, service, servic		20a. Method of Disposition 1 □ Burial 2 🛱 Cremation 3 □ Rer	noval from State	20b. Place of D	Disposition (Name of crematory or other p		Date	20c. Location	- City or To	wn, State
9	t. Pag t. Pag ntment rtant: I		4 □ Donation 5 □ Other (Specify) 21. Signature of Funera Service tiousee		Hillton	Service		THE STATE OF THE STATE OF	Towson		
	permit. Departr Importa any inji		Hay WHO	jan		22. Name and Add	k Road	Towson,	Marylan		ome, Inc. 204
			23a. Part1. Enter the disease, or complications, or heart failure. List only one Immediate Cause (Final	dions that caused the cause on each line	he death. Do no	t enter the mode of d	ying, such as cai	rdiac or respiratory a	arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or 1s a	nsequence of	· hring	ny o	rigin			
	Examiner	Ļ	Sequentially list conditions, b.	de	ment	100					
	nted Insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or se a	consequence of).					
	O, s execu en and rrial-tra	Exa	that initiated events resulting in death) Last	Due to (or as a	consequence of):		· · · · · · · · · · · · · · · · · · ·			
1	cate be executed physicien and the burial-transit	dical	d.								
PS :	wrequires that the death certificate signed by the attending should be detached for use as	by Physiclan/Me	IF FEMALE: 236. Was decedent pregnant in the past 12 months? 1	c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti	Fetal death	3 □Ectopic pregnal 5 □ Other (specify)			T .	ate of delive	ery Day Year
6	that the	, Phy	Part II. Other significant conditions contr	ibuting to death but	not resulting in t	he underlying cause	given in Part I.	23e. Did	tobacco use con	tribute to th	ne cause of death?
-	orus quires an sign	ed b	Sei	zure	disi	me		1 🗆	Yes 2 No	3 Prob	ably 4 Unknown
Ċ	S S S	Completed							s an 24b.	Were autop prior to con death? 1 \(\sum \text{Yes} \)	psy findings available mpletion of cause of
	VICAL INE sician: The la certificate ha irector, page 2	Be	25. Was case referred to medical examiner?					Death (Check only			
3	Of VICA Physician: r this certific ral director,	5	1 ☐ Yes 2 ☐ No Ho 27. Mann	spital: 1 Inpatient 28a. Date of Injury		atient 3 DOA	1	ng Home 5 ☐ Res 28d. Describe	idence 6 Ott	-	1)
	Attanding F r death. ector: After by the funer.	atlon	1 atural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	Ye <i>ar)</i> Inj	ury V	lork? □ Yes 2 □ No		,		
	DIVIS al or Atta s after des il Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur- building, etc.	y - At home, farn (Specify)	n, street, factory, offic	ee		(Street and Num. own, State)	ber or Rura.	l Route Number,
	To the Hospital or Attant within 24 hours after death To the Funeral Director: completely filled in by the	edical (29a. Certifier 1 Certifying Physic (Check only one) 2 Medicel Examine	cian: To the best of or: On the basis of e and manner state	xamination and/	death occurred at the or investigation, in m	time, date and p y opinion, death	place, and due to the occurred at the time,	cause(s) and m , date and place,	anner as st and due to	ated. the cause(s)
	To the vithing To the comp	Ň	29b. Signature and title of certifier) , 4	h (29c. Lice	nse number	Name	29d. Date signe	ed (Month, I	Day, Year)
	1		30. Name and address of person who com	uplated cause of do	ath (Item 32a) T	vne Print	() 2	1010	1012	0 0	
	/		Bruce Burne	who	- W)	8800 r	17h	いけして	1 lan	Liv2	llc Md
	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar	's Signature	Spark					((-))

		State	State of Marylan		rtment of Health			0001	20220
		Registrar 1. Decedent's Name (First, Middle, Last)					2. Date of Deat	_	3. Time of Death
Physicia /Medic		Dorothy			olenas		June	26,2004	06:10 AM
Examin	er	4a. Facility Name (If not institution, give str. Johns Hophis 60		ter	Baltime			4c. County of Deat	1
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. i		If Under 1 Year If Und		8. Date of Birth (Month, Day,	9. Birtl	nplace (State or Foreign
Director		213-07-2704	1 2 3 F 87	Yrs.	Months Days Hour	rs Min.	January.	31,1917 Mar	ÿTand
land ow	}	Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Loc	ation				10d. Inside City Limits
a-f sh	cto	MD Prince Geo	orges Laur	`e1					1 Yes 2 No
death with the Maryland ms 23a or 28a-f show Imaal be notified at	Director	10e. Street and Number			10f. Zip Code			0g. Citizen of What Co	untry?
eath v		15706 Dorset Road 11. Marital Status	Apt. 201 Was Decedent Ever in U.	S 13 W	20707	Origin? (Spec		JSA 14. Race - Ame	ican Indian
after d	Funeral	1 Never Married 2 Marned	Armed Forces? 1 ☐ Yes 2√1 No If Yes, Give	If	as Decedent of Hispanic Yes, specify Cuban, Mexi		Rican, etc.)	Black, White	, etc.
10 Z1Z13-UU30 s filed within 72 hours after death with the Marylan It Hygiene. other than "natural", or Itams 23a or 28a-1 show vent, the Medical Examiner must be notified at	d by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		□ Yes 2 No Spec	city:		Specify: Wh	ite
in 72 h	Completed	15. Decedent's Educa (Specify only highest grade of	ompleted)	(Give I	ent's Usual Occupation and of work done during m ONOT use retired)	nost of workin	9	16b. Kind of Business/I	ndustry
d with d with giene.	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Homema	,		C)wn Home	
iana z 1 z Id be filed withi ental Hygiene. ked other than ic event, tra M	Be	17. Father's Name (First, Middle, Last)					(First, Middle, M	faiden Sumame)	
Z should be and Mental Is marked of aumatic ev	은	Carroll Dorney 19a. Informant's Name/Relationship (Type	Orint)	10h Mailin	Address (Street and Num		crude Cr		
≥ 5€2;		D. Lee Zolenas / o			Dorset Road				
ore, of Hea fitem r othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Ren	20b. P	lace of Dispos	ition (Name of atory or other place)			20c. Location - City or 1	
Saltimor Dermit. Pages Department of mportant: if it any injury or o		' 4 ☐ Donation 5 ☐ Other (Specify)	Arli	ington Na	ational Cemeter	y 7/22/	/04 A	rlington,	VA
baltimo		21. Signature of Funeral Service Littensee	2 -		Name and Address of Fa		llome	1050 York	
		23a. Part 1. Enter the disease, or complica	tions that caused the death			7.6-		Towson, M	Approximate
Physician		shock, or heart failure. List only one Immediate Cause (Final disease or condition	//	er 's	Demen	tia			Interval Between Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a consequ						1. 1040 5
S. Willes	9	Sequentially list conditions, b.	Due to (or as a consequ	enca off.					
uted	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	·						
e exection and urrial-tr	Exa	resulting in death) Last	Due to (or as a consequ	uence of):					
icate be executed physicien and site burial-transit	dical	d.							
BOX O	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c	. If yes, outcome of pregna					23d. Date of deliv	/erv
death death ne atte	sicia	in the past 12 months? 1 Yes 2 No	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
D. T. de by the detache	Phy	9 ☐ Unknowh Part II. Other significant conditions contri		ulting in the un	darking aguas guras in Da		23a Did tob	acco use contribute to	the account death?
HECONGS, P.O. BOX 68/60, The law requires that the death certificate be executed the has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit.	d by	chronie obstru	•	-			1 Yes		bably 4 Unknown
aw req	olete	ostena-th-itis	OSteop	000 5	. ,		24a. Was an	24b. Were aut	opsy findings available
VICAL MEC sician: The law s certificate has b lirector, page 2 s	Completed		,				autopsy perform		empletion of cause of
Or VICAL Physician: 1 This certifical ral director, p	Be	25. Was case referred to medical examiner?	nita()		0		Check on one		
Phys r this or	2: To	1 Yes 2 No	28a. Date of Injury	ER/Outpatient 28b. Time of				nce 6 Other (Special of the Control	(y)
nding ath. r: Afte	atior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	28c. Injury at Work? M 1 ☐ Yes 2			,,	
INISION I or Attending after death. Director: Afte	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	et, factory, office	28	Bf. Location (Str. City or Town,	eet and Number or Rui State)	al Route Number,
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	ai Ce	29a. Certifier Certifying Physic	ian: To the best of my know	wledge death	populared at the time, date	and place of	ad due to the see		
ne Hos 24 h ne Fun detely	edica		r: On the basis of examinat and manner stated.	ion and/or inve	estigation, in my opinion, d	death occurred	d at the time, da	te and place, and due t	o the cause(s)
To the comp	ž	29b. Signature and title of certifier	Geriativ	Follow	29c. License numbe		_	d. Date signed (Month,	
		J.M.D.			D5950			nnc 26, 2	
7	į	30, Name and address of botson who com	oleted cause of death (Item 550 5 H	23a) (Type, P	Bayner C	Comple	Balti	mad ALA	21224
Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ure		000	1 10 - 1111	-140	2,077
Registra	ar	JUN 2 8 2004	Signer /	po!	ness				

			1 = For State Registrar	State of Maryland / Department of Maryland / D		d Mental Hygi	-	20231
			Decedent's Name (First, Middle, Las			2. Date of Death	3	3. Time of Death
	Physici		Theresa Buono			June	3 2004	4:30p ^M
>	/Medic		4a. Fecility Name (If not institution, give		4b. City, Town, or Location of Di		4c. County of Death	4.50p
	LXAIIII	lei	211 Dorchester		Cambridge		Dorches	tor
	Funeral		5. Social Security Number 6. Se		If Under 1 Year If Under 24 H			
	Director			□ M 254 F 86 Yrs.	Months Days Hours M	in. (Month, Day, NOV. 16	, 1917 Peni	ace (State or Foreign try) nsylvania
7			Usual Residence of Decedent			1100. 10	, 1517 TCII	isyrvania
7	how		10a. State 10b. County	10c. City, Town or Lo			10	d. Inside City Limits
Y:	Ba-f.s	to	MD Dorch	ester	Cambridge			1 XYes 2 ☐ No
2	or 28	ire	10e. Street and Number		10f. Zip Code	10	g. Citizen of What Count	try?
5	death with the Maryland ims 23a or 28a-f show	a	211 Dorchester A	ve.	21613		U.S.A.	
0	8 E E	ner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No-	14. Race - America Black, White, e	
9	or th	F	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 😿 No	1 ☐ Yes 2 🛣 No Specify:	ono moun, etc./		
Ö	oe lied within 72 hours after lat Hygiene. d other than "natural", or ite event, the Medical Example.	Completed by Funeral Director	3 XWidowed 4 □ Divorced	Year or Dates:	TE 103 Eysillo Opecily.		Specify: Wh	rce
h i	natu	ete	15. Decedent's Edi (Specify only highest grad	ucation 16a. Decedor (Give	dent's Usual Occupation kind of work done during most of DO NOT use retired)	working 1	6b. Kind of Business/Ind	ustry
2	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ם	Elementary/Secondary (0-12)	College (1-4or 5+)				
7	ygie rt.	ပိ	17		bookbinder		printing	
בו ב	d of	Be	17. Father's Name (First, Middle, Last)			lame (First, Middle, M		
2	should and Men s marke umatic	²	Maximo Buono			helina Cibe		
Jai			19a. Informant's Name/Relationship (T		ng Address (Street and Number or			
6	Health Health tem 27 I				Dusty Miller C	The state of the s		20637
o d	of H		20a. Method of Disposition 1 X Burial 2 Cremation 3 Di	Removal from State	sition (Name of natory or other place)	Date 2	0c. Location - City or Tov	vn, State
E	rages ment of ent: If it		`4 Donation 5 Other (Specify		arket Cemetery	5/9/04 I	East New Mar	ket, MD
Baltimore, Maryland 21215-0036	Departr Departr Importe any inju		21. Signature of Funeral Service Licens	22	. Name and Address of Facility	Thomas Fune	eral Home P.	Α.
	2011	20 1	Drink. J		O Locust St., C	ambridge, N	D 21613	
4.8			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death. Do not ent one cause on each line.	er the mode of dying, such as card	iac or respiratory arres	st,	Approximate Interval Between
P	hysician		Immediate Cause (Final disease or condition	LINDER TE	7/10/1/		6	Onset and Death
	/Medical		resulting in death)	a. Due to (or as a consequence of):	1031010		7	er years
Ŀ	xaminer		Cognostiathy list conditions	, Osteocertus	itis		K	En yes
7	, =	Examiner	Sequentially list conditions, any, scange to manufacture cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):				
9	ind	ап	Cause (Disease or injury that initiated events resulting in death) Last	С				
760,	lysician and he burial-transit	Ω.	1930king in Geatiff Last	Due to (or as a consequence of):				
	hysic the b	ilcal		d				
Hecords, P.O. Box 68	attending phy for use as the	by Physician/Med	IF FEMALE:					 -
Box	ttend or us	an/	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy		23d. Date of deliver	•
j.	the a	SICI	1 ☐ Yes 2 € No 9 ☐ Unknown	4☐Pregnant at time of death 5☐ 9☐Unknown	Other (specify)		MORE!	Day Year
7. E	ed by the adelached	Phy						
Ś	igned be de	by	Part II, Other significant conditions co	entributing to death but not resulting in the un	nderlying cause given in Part I.		cco use contribute to the	_
Hecords,	been si	Completed				1 L Yes	2 No 3 Proba	biy 4 Unknown
e c	hasb je 2 st	ple				24a. Was an autopsy	24b. Were autop:	sy findings available pletion of cause of
X		Ю				performe	od? death? ☑No 1 ☐ Yes 2	
Vital	certificate rector, pag	Be (25. Was case referred to medical examiner?		26. Place of D	eath Check on one		
VISION Of VITA	after doath. Director: After this certific In by the funeral director.	2	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	t 3 DOA Other: 4 Nursing	Home 5 esiden	ce 6 Other (Specify)	
	fter t		27. Manner of Death 1. ■Natural 5 □ Pending	28a. Date of Injury 28b. Time of Injury Injury	28c. Injury at Work?	28d. Describe how	injury occurred	
010	or: A	atle	2 ☐ Accident investigation		M 1 ☐ Yes 2 ☐ No			
DIVISION OF	after de Direct	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, stre building, etc. (Specify)	eet, factory, office	28f. Location (Stre City or Town,	et and Number or Rural i State)	Route Number,
ב ב	rs aff	Cer					,	
200	Funerel Funerel	ca	29a. Certifier Certifying Phy (Check only 2 Medical Exemi	rsician: To the best of my knowledge, death iner: On the basis of examination and/or inv	occurred at the time, date and pla	ce, and due to the cau	se(s) and manner as sta	ted.
94	within 24 hours after To the Funeral Dir. completely filled in	Medical	1	and manner stated.				
5	To	2	29b. Signature and title of certifier	<i>i</i> , , , , , , , .	29c. License number	290	I. Date signed (Month, De	ey, Year)
			· Unwelst	en affecting the	u 215541.		6/4/04.	
				ompleted cause of death (Item 23a) (Type, I			24.54.5	
			Vinodrai Mel	11717	Byrn St., Cambr	nage, MD	21613	
	Sta Registr	1.3	31. Date filed (Month, Day, Year) JUN 0	7 2004 Signature	house			

			1 - For State Registrar		Department of Health and Certificate of Death	Mental Hygie	2001	20232
	Physici /Medic		1. Decedent's Name (First, Middle, Last)		*MBROSE		Day Year	3. Time of Death
	Examin	er	4a. Fecility Name (If not institution, give s THE JOHNS HOPKINS	HOSPITAL	4b. City, Town, or Location of Deat BALTIMORE CIT	Y	4c. County of Death	
	Funeral Director		5. Social Security Number 6. Sex 132–20–2419 Usual Residence of Decedent	Au 200 E	thday) If Under 1 Year If Under 24 Hrs Months Days Hours Min.	B. Date of Birth (Month, Day, Ye July 15,	10.70	place (State or Foreign intry) New York
Maryland	ef show	tor	10a. State 10b. County	10c. City, Town	n or Location			10d. Inside City Limits 1 ☐ Yes 2 ♠No
with the	3s or 28s	ai Director	10e. Street and Number 252 Brookline Co		10f. Zip Code 21140		Citizen of What Cou Inited Sta	
5-0036 72 hours after death with the Maryland	ıtal Hygiene. ıd other then "netural", or Items 23a or 28a-f show event, Ite Medical Examiner must be notified at	by Funerai		12. Was Decedent Ever in U.S. Armed Forces? 1 dmYes 2 □ No If Yes, Give Year or Dates: 1945–194	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 Yes 2 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White Specify:	
21215-0036 3d within 72 hours af	ne. hen "netur e Medical I	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation 16a. s completed) College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of wo- life. DO NDT use retired)	king	. Kind of Business/Ir	
land 21	fental Hygier rked other ti tic event, III	To Be Co	17. Father's Name (First, Middle, Last) John P. Ambrose	5+	president 18. Mother's Nam Edith J	ne (First, Middle, Maid	environmen den Sumame)	ita1
, Maryland and 2 should be file	f Health and Meritem 27 is marke other traumatic		19a. Informant's Name/Relationship (Type John P. Ambrose	III/ son 4	Mailing Address (Street and Number or Riv 22 Berkshire Dr. Riv	a MD 21140		p Code)
(I)	Department of Hea Importent: If item an njury or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	emoval from State cemeter St. Ma	(#	9, 2004 hn M. Tayl	or Funera	MD 1 Home, Inc
1	hysician and Medical was the burial-transit	ical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	PNEUMONIA Due to (or as a consequence of	not enter the mode of dying, such as cardiac enter the mode of dying, such as cardiac of): ncreatic Cancer N or):	or respiratory arrest,		Approximate Interval Between Onset and Death ICO DAYS
I Records, P.O. Box 68 The law requires that the death certifics	by the attending phached for use as ti	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delive	ery Day Year
rds, P quires that	s been signed b should be deta	by	Part II. Other significant conditions con	tributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacc	co use contribute to t	
al Records, The law requires the	cate has bee , page 2 sho	Completed				24a. Was an autopsy performed	? prior to co	ppsy findings available impletion of cause of
of Vita Physician:	certificate rector, pag) Be	25. Was case referred to medical examiner?	ospital:	Other	th (Check only one)		
Division of Vital	e te	ation: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury 28b. T	Ipatient 3 □ DOA Outlet 4 □ Nursing H Time of piury 28c. Injury at Work? Work? N 1 □ Yes 2 □ No	ome 5 Residence 28d. Describe how in		fy)
Divis	within 24 hours after death. To the Funeral Director: Af completely filled in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, far building, etc. (Specify)	rm, street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rura ate)	al Route Number,
he Hospi	in 24 hour he Funer pletely fill	edical	one) 2 Medical Examir	sician: To the best of my knowledge ner: On the basis of examination and and manner stated.	, death occurred at the time, date and place d'or investigation, in my opinion, death occu	, and due to the cause rred at the time, date a	(s) and manner as s and place, and due t	stated. o the cause(s)
Tot	with To 1	Σ	29b. Signature and title of certifier	c. Padho	M.D. RES-000		Date signed (Month, NE 04, 2	
				D. JOHNS HOPKINS	Type, Print) S HOSPITAL GOONORTH WOLL			
	Sta Registr		31. Date filed (Month, Day, Year) 7 2	32. Rigistrar's Signature	Small 1			

			For State Registrar	State	of Marylar		artment of				- 00	04	20233
			Decedent's Name (First, Midd	le, Last)						2. Date of De.	ath Day	Yeer	3. Time of Death
	Physicia /Medic		Anna Regina	Allison						June 9		1001	00:30 a ^M
10	Examin		4a. Fecility Name (If not institution		number)		4b. City, Town	, or Locatio	n of Death		4c. Count	ty of Deeth	1
			Howard County	General	Hospita	1	C If Under 1 Yea	olumb	ia er 24 Hrs.	O Data of Bird		Howai	
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🖫 F	7. Age (In yrs.	. <i>Iast birtnday)</i> Yrs.	Months Day			8. Date of Bird (Month, De 12/10/1	W Voorl	Cou	plece (State or Foreign untry)
	Director	1	332–16–7425 Usuel Residence of Decedent		83					12/10/	1920		MI
	yland		10a. State 10b. County	1	10c. C	ity, Town or Lo	cation						10d. Inside City Limits
	Mariet	tor	мр н	oward			E	lkrid	ge				1 X Yes 2 □ No
	or 28	Director	10e. Street and Number				10f. Zip Code				10g. Citizen of	What Cou	untry?
	ath w 230	rall	6394 Beechfie			10		L075	0:::0:0-	- V - V N -	USZ		ican Indian,
	er de	Funeral	11. Marital Status	Armed I	ecedent Ever in U Forces? s 2] No	J.S. 13.	Was Decedent of If Yes, specify Co	t Hispanic (uban, Mexic	origin? (Sp can, Puerto	Rican, etc.)	Ble	eck, White	
36	Ir, or	by F	1 ☐ Never Married 2 ☐ Mai 3 🔀 Widowed 4 ☐ Divorce	If Yes. C	Give Dates:		1□Yes 2XIN	o Speci	ity:		Speci	fy: W	nite
21215-0036	within 72 hours after death with the Maryland ene. than *naturel', or tlems 23e or 28e-f ehow he Madical Evana'nd hidel be notified at	ted		nt's Education	-0	16a. Dece	dent's Usual Occ	supation	net of work	ina	16b. Kind of E	3usiness/l	ndustry
212	hin 7	pie	Elementary/Secondary (0-12)	est grade completed College	(1-4or 5+)	life.	kind of work dor DO NOT use ret	red)	osi oi work	"'y	_		
	filed wi Hygien Sther th	Completed	12			1	Homemak		4bl - \$1	- /Fires & distrib	l	wn Ho	ome
nd	be fill d off	Be	17. Father's Name (First, Middle							e (First, Middle,		тө)	
3	should I nd Meni marke umatic	ပို	Jacob Schwer 19a. Informant's Name/Relation			10h Maili	ng Address (Stre			Bauiman		State 7	in Code)
Maryland	nd 2 sho alth and 27 is m or traum		Clarence Kocher		าท		4 Beechf					210	
	1 and Health tem 27 other tr		20a. Method of Disposition	Idol Lety be	20b.		osition (Name of matory or other p			Date	20c. Location	- City or T	Town, State
<u>o</u> E	ages ant of t: If I		1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (m State		itan Cre		6/11/	2004	Alexand	lria,	Virginia
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel", or Items 23e or 28a-f ehow any injury or other traumatic avent, the Marical Exament must be notified at 20ce.		21. Signature of Suneral Service		110		2. Name and Add		cility Ra	vmond-W	lood Fur	nera1	Home, P.A.
ä	Depa Impo any in		16.W	000	•		PO Box 4	30, I			20754		
	A.		23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that it only one cause of	t caused the dea	ath. Do not en	ter the mode of o	lying, such	as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	a +	seur	nnes	ノ						Oriset and Death
4	/Medical Examiner		resulting in death)	Due t	to (or as a conse	quence of):		1.0					
Н	e e	100	Sequentially list conditions,	b	o (or a conse	quence of):	The .	Jack		,			
	ted nsit	nln	rany, leading to immediate cause. Enter Underlying Cause (Disease or injury	1	to	20.00	1 cilul						
Ć,	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due t	o (or as a conse	guence of):	Da.	<u> </u>		^ ·			
760,	0 0 0	cai		o. Ch	mu (Tb5hu	ilen	le	rupe	Disex	se_		
9	leath certificat attending phy ifor use as th	Aedi	IE EENAN E.						,				
Вох	death certifica e attending ph id for use as th	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 13 months?		outcome of pregree birth 2 Fel	tal death 3[Ectopic pregna					ate of deli-	very Day Year
.O.	0 0 0	Physician/Med	in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	4□Pre 9□Uni	ignant at time of known	death 5[Other (specify)						,
<u>o</u> .	law requires that the das been signed by the 2 should be detached		Part II. Other significant condit	tions contributing to	death but not re	sulting in the u	inderlying cause	given in Pa	rt I.	23e. Did t	obacco use cor	ntribute to	the cause of death?
ds,	signe d be	d by		mentin			, ,			10	Yes 2□No	3 🗆 Pro	obably 4 Unknown
Record	w requir been si should	ompieted	V							24a. Was	an 24b	Were au	topsy findings available
Re	0 = 0	m d m									rmeg?	prior to c death? 1 \(\subseteq \text{ Yes}	ompletion of cause of 2□ No
Vital	ician: Th certificate ector, pag	O	25. Was case referred to medic	al				26. Pla	ace of Deat	1 ☐ Yes	2/No	1 🗆 162	20 140
<u> </u>		To B	examiner? 1 Tyes 2 No	Hospital:	npatient 2	☐ ER/Outpatie	nt 3 DOA	Other: 4 🗆	Nursing Ho	ome 5 Resi	dence 6 🗆 Ot	ther (Spec	ity)
n of			27. Manner of Death 1 Natural 5 ☐ Pend	/8.4	te of Injury onth, Day Yeer)	28b. Time of		ljury at Vork?			how injury occu		
Sio	Attending r death. ctor: After by the fune	catle		tigation				Yes 2	□No	004.1 - 11 - 1	20.		10 10
Division	for Attendate death Director:	Certification:		mined 288. Pla	ice of Injury - At liding, etc. (Spec	home, farm, st cify)	reet, factory, offic	08		City or To		iber or Hu	ral Route Number,
	Hospital or 14 hours afte Funeral Dir tely filled in		29a. Certifier 1 Certify	ing Physician: To I	the best of my kr	nowledge dea	th occurred at the	time date	and place.	and due to the	cause(s) and m	nanner as	stated.
	Hos 24 hc Fun etely	edical	(Check only 2 Medics	I Examiner: On the	basis of examir anner stated.	nation and/or in	vestigation, in m	y opinion, o	death occur	red at the time,	date and place	, and due	to the cause(s)
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Me	29b. Signature and title of certif	191			29c. Lice	ense numb	er		29d. Date sign	^	
	->-0		1 Sen	- Le	-ND		77.5	087	70		JI. se	-9th	2004
	,		30. Name and address of perso				Print)						
_	6		Suzan Abdo, M	.D. 5005			ne, Clar	ksvi1	1e, M	D 21029			
		ate	31. Date filed (Month, Day, Yea	(r) 32	. Registra sign	nature							
	Regist	rar		T T 500.	JUGADU	w xx	6134						

			_ State	tate of Maryland / Dep	partment of Fertificate of			2001	20221
			Registrar 1. Degedent's Name (First, Middle, Last)		ertinicate or		Reg 2. Date of Death	1. No. UU4	3. Time of Death
Pt	nysicia		Constance Als	io ¬			Month	9 - 200 4	7:50 a M
	Medic xamin	_	4a. Facility Name (If not institution, give stre		4b. City, Town, o	r Location of Death		4c. County of Death	7.30 a
	Admini		Millenium South River	144 WAShington K	Edger	water m	0	AA	
Fur	neral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthda)	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	'ear) Cour	lace (State or Foreign
Dire	ector		212-86-1441	280 F 40 Yrs.			an. 26		y'land
and		-	Usuel Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location			1	0d. Inside City Limits
Mary		ğ	Maryland Anne Aru	ndel Annapol	is				1 (∑Yes 2 □ No
the 28s	Tage 1	rec	10e. Street and Number	IId CI	10f. Zip Code		100	g. Citizen of What Cour	ntry?
:1215-0036 within 72 hours after death with the Maryland ene.	4	Funeral Director	9 College Creek	Terrace	21401			USA	
r deal		ner	11. Marital Status 12.	Was Decedent Ever in U.S. 13 Armed Forces?	Was Decedent of H	lispanic Origin? (Specan, Mexican, Puerto P	cify Yes or No- lican, etc.)	14. Race - Americ Black, White,	
36 safte	1	by Fu	1 □ Never Married 2 ☑ Married	1 ☐ Yes 2 ☐ No If Yes, Give	1 ☐ Yes 2 ☒ No	Specify:		Specify: B1	ack
21215-0036 ad within 72 hours af rgiene.	a Ex	g p	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educat	Year or Dates:	edent's Usual Occup	ation	16	6b. Kind of Business/Inc	dustry
7. S	Apple	Completed	(Specify only highest grade of	ompleted) (Giv	re kind of work done DO NOT use retired	during most of workin	a	nnapolis	
212	3	E	Elementary/Secondary (0-12)	College (1-4or 5+) Cr	ossing G	Guard	1	olice Dep	-
be filed stal Hygid	vent,	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name		_	
Vlai Ment	sumatic event, the Medical Exerviner roust be notified at	ဥ	James M. Boo			.,,	et Ree		-
Maryland nd 2 should be file slith and Mental Hy			19a, Informant's Name/Relationship (Type,	100				City or Town, State, Zip shington,	
e, P	thar t		Richard Alsop Bro	own (Husband) 20b. Place of Disp		Di Di		oc. Location - City or To	
ages nit of H	0.0		1 ☐ Burial 2X Cremation 3 ☐ Rem	oval from State Metro C	ematory or other place or y	6/10		altimore,	_
Baltimore, sermit. Pages 1 a Department of Hearman	iniga.	1	* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee		22. Name and Addre		,, 01	<u>a</u>	
Baltimore, Marylar permit. Pages 1 and 2 should be Department of Health and Menta	any ir	Н	Jarry A. Leese	Mc0483	Vm. Reese	e & Sons	Mortua	rуа. Р.А.	11
			23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one	ions that caused the death. Do not e	nter the mode of dyir	ng, such as cardiac or	respiratory arres	t,	Approximate Interval Between
Physi	ician		Immediate Cause (Final disease or condition	ASSURED IN	unrele	Diciences	Vivu	٨	Onset and Death
/Me	dical		resulting in death)	Due to (or as a consequence of):		Tourney			
Exan	niner		Sequentially list conditions, if any, leading to immediate	D1- (- 1			
pe	sit	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c	Due to (or as a consequence of):					
xecut	al-tran	Examiner	that initiated events c resulting in death) Last	Due to (or as a consequence of):					<u></u>
Records, P.O. Box 68760, The law requires that the death certificate be executed	physician and the buriat-transit	dicai E	L _d .						
68 tificat	as th	ledi							
Box eath cert	allending p	an/N	23b. was decedent pregnant	If yes, outcome of pregnancy 1□Live birth 2□Fetal death 3	Ectopic pregnancy	,		23d. Date of delive	,
O deal	me ann	sicia	in the past 12 months? 1 Yes 2 No		Other (specify)	·		Month	Day Year
P.O.	ac o	by Physician/Me	9 ☐ Unknown Part II. Other significant conditions contri	outing to death but not resulting in the	underlying cause giv	ren in Part I	23a Did toba	cco use contribute to the	ne cause of death?
ds, lires t	D 0	d by	Encoplia Po	within .	underlying dadde giv			2 No 3 Prob	
y requ	should	lete	Calpand	Dela D. O.			24a. Was an	24h Were auto	psy findings available
Re la	page 2	Completed	g-cieras	3 collection			autopsy performe	prior to cor death?	npletion of cause of
tal	certificate rector, pag	Be C	25. Was case referred to medical			26. Place of Death		No 1 ☐ Yes	2L No
of Vita	± 5 €	ToB	examiner?	pital: 1 Inpatient 2 ER/Outpati	ent 3 DOA Oth	22		ce 6 Other (Specify	")
O H H gr	neral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury 28b. Time (Month, Day Year) Injury		y at 21	d. Describe how	injury occurred	
Vision Attending	the fu	catio	2 Accident investigation			Yes 2 □ No			
Division of Vital Records, if or Attending Physician: The law requires that after death.	in by	Certification:	4 Homicide determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	21	City or Town,	et and Number or Rura State)	l Houte Number,
To the Hospital within 24 hours a	l o the Funeral Director: After in completely filled in by the funeral		29a. Certifier A 1 Certifying Physic	an: To the best of my knowledge, de-	ath occurred at the tir	me, date and place, as	nd due to the caus	se(s) and manner as st	ated
24 hos	e rur letely	edical		On the basis of examination and/or and manner stated.					
To the within	dwoo	Me	29b. Signature and title of certifier		29c. Licens	e number	290	I. Date signed (Month, I	Day, Year)
			P		DE	57028		6-9-0	4
			30. Name and address of person who comp	pleted cause of death (Item 23a) (Type	e, Print)		0		
			31. Date filed (Month, Day, Year)	212 MD 600 F	idgely!	Aue. Stc.	(31 Hm	napolis,n	10.21401
R	Sta Registr		JUN 1.1 200		Shoots 5				

			ricase	* *	midelible lik. Elisure A	•	9	
			For State	-	epartment of Health and		2001	20005
			Registrar		Certificate of Death	Re	eg. No. UU4	20235
			Decedent's Name (First, Middle, L.	ast)	-	2. Date of Deatl	h Day <u>Y</u> ear	3. Time of Death
	Physici /Medio		Joseph Vince	nt Bealbowsh	Sr.	06	09' 04	1142 AM
	Examin		4a. Facility Name (If not institution, gi		4b. City, Town, or Location of Deat	h	4c. County of Deat	h
1			12032 Appalac	hian Court	Smithsburg 1	MA	WASHIN	15-70 W
	Funeral			Sex 7. Age (In yrs. last birth	day) If Under 1 Year If Under 24 Hrs	8. Date of Birth	9. Birt	hplace (State or Foreign untry)
	Director		090-12-4108	1⊠M 2□F 82	rs. Months Days Hours Min.	(Month, Day, MARCH 15	1922 N	EW_YORK
	D		Usual Residence of Decedent				, 1/22 1	
	show		10a. State 10b. County	10c. City, Town	or Location			10d. Inside City Limits
	Man Man	io	MARYLAND WASHI	NGTON	SMITHSBU	RG		1 ☐ Yes 2 🙀 No
	or 28a-f	Director	10e. Street and Number		10f. Zip Code		g. Citizen of What Co	untry?
	within 72 hours after death with the Maryland ane. than "naturai", or items 23e or 28e-f show he Nealcal Examinar must be notified at	<u></u>	12032 APPALACHIA	N COURT	21783		U.S.A	
	deatl ms 2	by Funeral	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	pecify Yes or No-	14. Race - Ame	rican Indian,
(0	or ite	Ē	1 Never Married 2 Married	Armed Forces?		to Hican, etc.)	Black, White	e, etc.
8	urs a	by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates: 1946	1 ☐ Yes 2 🛣 No Specify:		Specify:	WHITE
21215-0036	72 hours after death wi "natural", or items 23a olical Examinar must b	Completed	15. Decedent's E		Decedent's Usual Occupation	1	16b. Kind of Business/l	ndustry
215	nin 7	ple	(Specify only highest gas Elementary/Secondary (0-12)	College (1-4or 5+)	Give kind of work done during most of wo life. DO NOT use retired)	King		
21	should be filed within the Mental Hygiene. marked other than matic event, the Mi	mo.	Zioliioniary, occorriatry (o 12)	1	SUPERVISOR		FEDERAL GO	VERNMENT
	other	Bec	17. Father's Name (First, Middle, Las	t)	18. Mother's Nar	ne (First, Middle, M		7
<u>a</u>	Mental Mental arked c	To B	JOHN BEALKOWSKI		FRANCES	KRYSTOFF	ı	
Maryland	2 should and Men 1s marke sumatic		19a. Informant's Name/Relationship	(Type, Print) 19b. i	Mailing Address (Street and Number or Ru		·	ip Code)
Š	C1 (0 = 0		JOSEPH BEALKOWSK	I JR./SON 120	32 APPLACHIAN COUR	T SMTTHS	BURG MARY	T.AND 21783
စ်	1 and Health tem 27 other tr	1	20a. Method of Disposition	20b. Place of D	Disposition (Name of		20c. Location - City or	
2	Pages nent of int: If it		1 Burial 2 Cremation 3	Hemoval from State	crematory or other place)	1 /000/		
Baltimore,	F # # :=		4 □ Donation 5 □ Other (Spec	ISMITHS!	BURG CREMATORY 6/1			
Ba	permit. Departimport any inj	1 1	16		BAST FUNERAL HOME		National	
		-	23a Part 1 Enter the disease obcor	Kelly A. Zimmerman		Boonsbor	o, Marylan	d 21713 Approximate
				one cause on each line.	ot enter the mode of dying, such as cardiac	or respiratory arre	st,	Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a Suicide				
	/Medical Examiner		1	Due to (or as a consequence of):			
		_	Sequentially list conditions,	b. Gurishot to the	head			
	pe is	Examiner	it any, leading to intri-ediate cause. Enter Underlying Cause (Disease or injury	Gea to (or se a noneaquence of	r			
	and tran	carr	that initiated events resulting in death) Last	c. Due to (or as a consequence of	Λ.			
760,	ate be executed hysician and he burial-transit	<u>=</u>	, , , , , , , , , , , , , , , , , , , ,	Due to (or as a consequence of)·		1	
87	ate b hysic the b	dical		d				
89 >	ing p	Mec	IF FEMALE:					
Вох	ath ca trend or us	an	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 □Ectopic pregnancy		23d. Date of deli-	very Dav Year
	e dea he al	sicl	1 ☐ Yes 2 ☐ No	4 Pregnant at time of death 9 Unknown	5 Other (specify)		Month	Day 16ai
P.0	The law requires that the death certifical ate has been signed by the attending phypage 2 should be detached for use as the	Physiclan/Med	9 Unknown					
	gnec gnec	by	Part II. Other significant conditions	contributing to death but not resulting in t	the underlying cause given in Part I.		acco use contribute to	
Records,	w requires to been signer should be considered.	Completed				1 🗆 Yes	s 2 Ø No 3 ☐ Pro	bably 4 Unknown
S	ne law r has be ge 2 sh	ple	<u> </u>			24a. Was an autopsy		opsy findings available ompletion of cause of
ď	The i	mo:				perform	ed? death?	
Vital	iclan: Th certificate rector, pag	Bec	25. Was case referred to medical		26. Place of Dea	ath (Check only one		
>	S S	To	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp	oatient 3 DOA Other: 4 Nursing H	ome 5 Resider	nce 6 Other (Spec	ify)
of of	fing Ph n. After th funeral		27. Manner of Death	28a. Date of Injury 28b. Tir (Month, Day Year) Inj	ne of 28c. Injury at work?	28d. Describe how	w injury occurred	
<u>o</u>	ath. r: Af	atlo	1 □ Natural 5 □ Pending 2 □ Accident investigation		AM 1□Yes 2MNo	Gunshot	to head	
Division	Atte	ific	3 Suicide 6 Could not determine		n, street, factory, office	Marin Control	eet and Number or Rui	al Route Number,
Ö	al or	Sert	4 _ Hornioldo	Hame		12032 Apr	Jachian Ct.	Smithsburg, mu 21783
	spit hours mera y fille	Medical Certification:	29a. Certifier 1 Certifying P	hysician: To the best of my knowledge,	death occurred at the time, date and place	, and due to the car	use(s) and manner as	stated.
	P HG	dic	(Check only 2 Medical Exa	miner: On the basis of examination and/ and manner-stated	or investigation, in my opinion, death occu	rred at the time, da	te and place, and due	to the cause(s)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	×	29b. Signature and title of certifier	D -1	29c. License number		d. Date signed (Month	**
	1		1 Hill	vento D.O. FACEP	H40884		06 09 0	4
-	11241		30. Name and address of person who	completed cause of death (Item 23a) (T	ype, Print)			
	H		Thomas I Gill	pert III D.O. FACE		St Har	pretnum	MD 21740
2	Sta	ate	31. Date filed (Month, Day, Year)	32. Rigistrar's Signature	1	/ 64	C. 3 - 00011 /1	0 10
	Registi		JUN 14	2004 Seem D.	Sparke			

			1 _ State	State of Marylan		nent of Health and	Mental Hygier	711111	20236
		Z.	Registrar 1. Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
	Physici /Medic		ETTA ELIZABETH BIT	NER			June 1	Day 2004	11:17 0
	Examin		4a. Fecility Name (If not institution, give st		4b.	City, Town, or Location of De		4c. County of Death	1
1	Funeral	1	5. Social Security Number 6. Sex	Nursing 7. Age (Inlyrs.	last birthday) If U	nder 1 Year If Under 24 H	rs. 8. Date of Birth		place (State or Foreign
	Funeral Director		212-14-6603	M 2XF 86	Yrs. Mor	nths Days Hours Mi	OCT. 4, 1	917	MARYLAND
_	and w		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Location	1			10d. Inside City Limits
	Maryla -f sho	Į.	MARYLAND WASHIN	JCTON		BOONSBORO			1 ☐ Yes 2 📉 No
	h the	Director	10e. Street and Number	VG LOIV	10	f. Zip Code	10g.	Citizen of What Cou	intry?
	ours after death with the Marylan ali, or Items 23a or 28e-1 show	ralD	8507 MAPLEVILLE RO			21713			5.A.
	items items	Funeral	11. Marital Status 1 Never Married Married	2. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 No	.S. 13. Was D	ecedent of Hispanic Origin? specify Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Amer Black, White	
036	ours at	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 🗆 Y	es 2X No Specify:		Specify:	WHITE
5-0	be tited within 72 hours after death with the Maryland lat Hygiene. Ital Hygiene. d other than "natural", or Items 23s or 28s-1 show svent, ir a Modical Examinar must be notified at	Completed	15. Decedent's Educa (Specify only highest grade		(Give kind o	Usual Occupation of work done during most of w OT use retired)	orking 16b	. Kind of Business/Ir	ndustry
121	within ene. than	Jup	Elementary/Secondary (0-12)	College (1-4or 5+)	ire. DO NO	SEAMSTRESS		CLOTHING	MANUFACTURE
5	illed withir Il Hygiene.	Be Co	17. Father's Name (First, Middle, Last)		1		ame (First, Middle, Maid		
<u> </u>	2 should be to and Mental His marked of raumatic ave	To E	WILLIAM CARL MOSER	l.	=1	KATIE	K. FORD		
Marvland 21215-0036	d 2 should be tiled within 72 h th and Mental Hygiene. 7 is marked other than "natu traumatic event, Ir a Medical		19a. Informant's Name/Relationship (Type		1	Iress (Street and Number or I			0.4 = 4.0
			BONNIE B. HENSON, D 20a. Method of Disposition	20b. F	lace of Disposition	LARDI ROAD, I		LOCATION - City or T	21713 own, State
altimore.	Pages nent of the int: if ite		1 XBurial 2 ☐ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify).	moval from State	emetery, crematory ONSBORO C		E 14, 04 E	OONSBORO.	MARYLAND
alti:	permit. Pages Department of Important: If I any injury or once.		21. Signature of Fune al Sen in The Insee			e and Address of Facility		NATIONAL	
\ m	82558		kej zy A. Zimier			T FUNERAL HOM		O, MARYLA	
3			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final	ations that caused the deat cause on each line.	n. Do not enter the	mode of dying, such as cardi	ac or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a conseq	struc lie	ent faille	u		2 month
0	Examiner		Commence of the line of the land of the la	polar	Ed Con	diamioha	They		Year
N	P #6	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	uence oi).	1 1	()		
2	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	uence of):	<u>n</u>			yeins.
760		calE	a.						
5/2			IE EEMALE.						
Sox Box	ath ce ttendii or use	an/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	 If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Feta 	Ideath 3 □Ectop	pic pregnancy		23d. Date of deliv Month	rery Day Year
, Ž	that the dei	Physician/Med	1 ☐ Yes 2 No 9 ☐ Unknown	4□Pregnant at time of d 9□Unknown	eath 5 □ Othe	r (specify)			•
	The law requires that the death certifica are has been signed by the attending phoage 2 should be detached for use as the	by Ph	Part II. Other significant conditions conti			ing cause given in Part I.	23e. Did tobacc	o use contribute to t	he cause of death?
, SA	v require been sig should b	ted b]	ernentic	1		1 ☐ Yes	2 No 3 □ Prol	bably 4 Unknown
	e lawre has be ge 2 sho	Completed	-112	erine can	1CCL		24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
							performed 1 Yes 2 Z	? death? No 1 Yes	2 □ No
Vital	ysician: The is certiticate hadirector, page	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ♠ No	spital: 1 Inpatient 2	ER/Outpatient 3	and the second s	eath (Check only one) Home 5 Residence	6 DOther (Special	6(1)
50	ing Phy I. Atter this tuneral o	n: T	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how in		,,
Sio	tendin leath. tor: Alt the tur	catlo	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		М	1 ☐ Yes 2 ☐ No			
Division	or Att atter d Direct in by	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, fa y)	ctory, office	28f. Location (Street City or Town, Sta	and Number or Run ate)	Il Route Number,
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the tuneral director,	edical Co	29a. Certifier (Check only one) Certifying Physic 2 Medical Exemine	er: On the basis of examina	wledge, death occu tion and/or investiga	rred at the time, date and pla- ation, in my opinion, death oc	ce, and due to the cause curred at the time, date a	(s) and manner as s	tated. o the cause(s)
_	o the o the omple	Mec		and manner stated.		29c. License number	29d. [Date signed (Month,	Day, Year)
			· Itym		To a second	D44996	Č	Fine 11	, 2004
_	3H.5		30. Name and address of person who com	pleted cause of death (Item	1 23a) (Type, Print)	12 Lappans	Ra net	nistano	MD 21713
	Sta Registr		31. Date filed (Month, Park ear) 4 20	32. Registrar's Signa	ture A.	KI			

Alverta H. Brinton Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			State of Marylar				Mental Hygie	•	•
		1 - For State Registrar			ificate of			No2 11 11	20237
Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Yea	3. Time of Death
/Media	cal	Alverta Henrie			th City Town	or Location of Dea	Tine.	7 200	4 340 PM
Examir	ner		du Nursina	Homo !	Dans	Cocation of Dea	ith	4c. County of De	wa tow
Funeral		5. Social Security Number 6. Sex	7. Age (In y)s.		If Under 1 Year Months Days	If Under 24 Hr Hours Mir		9. B	inthplace (State or Foreign
Director		220-26-7389 Usual Residence of Decedent	M 2 € F 87	Yrs.	Jays	7.00.0	June 11,	1916	Canada
aryland •how		10a. State 10b. County	10c. Ci	ty, Town or Loca	tion	<u> </u>			10d. Inside City Limits
the Mar 28a-f et Dottified	Director	Maryland Washing	ton		Hage	erstown			1 □ Yes 2√2No
.≨ ŏ <u>%</u>		10e. Street and Number			10f, Zip Code		10g	. Citizen of What (Country?
death w	Funeral		Point Road 2. Was Decedent Ever in U	I.S. 13. Wa	s Decedent of h	21740 Hispanic Origin? (Specify Yes or No-	14. Race - An	anada
or its		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2XXNo If Yes, Give		′es, specify Cub ∃Yes XXNo	an, Mexican, Puè Specify:	rto Rican, etc.)	Black, Wh	ite, etc.
72 hours "natural",	ed by	3 Widowed 4 Divorced	Year or Dates:					Specify:	White
n "na	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give kir life. DC	nt's Usual Occup nd of work done NOT use retire	during most of world)	orking 16	o. Kind of Busines	s/Industry
TO 100 100 100 100 100 100 100 100 100 10	E O	Elementary/Secondary (0-12)	College (1-4or 5+)	<u> </u>	Housewit	e		Hom	ne
be filed ital Hygid of other event,	Be	17. Father's Name (First, Middle, Last)				18. Mother's Na	ame (First, Middle, Ma	den Sumame)	
hould be d Mental marked o matic eve	ဥ	Henry Edward OE 19a. Informant's Name/Relationship (Typ	ell Taylor	10h Mailing	Address (Street		e Lulla k Rural Route Number, C	Cimberly	T- 0- 4-1
s 1 and 2 should be filed f Health and Mental Hyg tem 27 is marked othe other traumatic event,		Esther E. Brinton-							
of Head		20a. Method of Disposition	20b. F	Place of Dispositi	ion (<i>rvame or</i>		Date 200	c. Location - City of	and 21740 r Town, State
Page ment ant: I		1 ⊠ Burial 2 ☐ Cremation 3 ☐ Re `4 ☐ Donation 5 ☐ Other (Specify)	moval from State	-	-	1	9,2004 Wi	Hiamspo	rt,Maryland
permit. Pages 1 and 2 should be 1 Department of Health and Mental 1 important: If item 27 is marked or eny injury or other traumatic eve pnce.		21. Signature of Lineral Service License	/.	Ost	of he are	meferir Ho	ome, P.A.		21795
		23a. Part . Enter the disease, or complic	ations that caused the deat				que St.Will	iamsport	,Maryland Approximate
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/Medical		disease or condition resulting in death)	Due to (or as a conseq	uence of):					100
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nted nsit	Examiner	Sequentially list conditions, fary, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	juence ot):					
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death certificat e attending phy of for use as th	Physician/Med	IF FEMALE:	a If was outcome of progns	1000					
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has by	ompleted						24a. Was an autopsy performed	prior to	utopsy findings available completion of cause of
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S S	To B	examiner?	ospital:	ER/Outpatient	3 DOA Oth		ath Check on one	6 Nother (Spe	ecify)
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death death stor: /	ertification;	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injury - Al he	ama farm street		Yes 2 No	296 Lagation (Ctua-		
after Direction by	ertl	4 Homicide determined	building, etc. (Specif	y)	, тастогу, оптсе		28f. Location (Stree City or Town, S	tand Number of H	urai Houte Number,
ospita hours uneral	calc	29a. Certifier 1 Certifying Physic (Check only 2 Medical Examin	cian: To the best of my kno	wledge, death or	ocurred at the tin	ne, date and plac	e, and due to the caus	e(s) and manner a	s stated.
To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	0.0,	er: On the basis of examina and manner stated.	ition and/or inves					
To Too	2	29b. Signature and title of certifier			29c. Licens	S35	29d.	Date signed (Mon	th, Day, Year)
		30. Name and address of person who con	poleted cause of death (tren	n 23a) (Type Pri		0002)	10104	
		Khalid M. Waseem,	M.D. 1126 O	oal Cour	t Hager	stown,Ma	ryland 21	740	
Sta		31. Date filed (Month, Day, Year) JUN 10 200	32. Registrar's Signa	A. A.	Es .	-			
Registr	ar	JUN 1 0 200	T MARKET A	1. Jalou					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day 2004 Charles Edward Buhl June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Hagerstown Washington County 473 Thames
5. Social Security Number Street If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. Min. (Month, Day, Year)

March 23,1931 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 DM 2 □ F 73 Director 375-30-3304 Usual Residence of Decedent Michigan permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Importent: if item 27 is marked other than "natural", or iteme 23a or 28a-f ehow eny injury or other treumatic event, the Marylasi Exprinter resulting an once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits XX Yes 2 No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 473 Thames Street U.S.A. 14. Race - American Indian, Black, White, etc. Funerai 21740 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Aviation Ordnance US Armed Forces 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Howard Kay Buhl Sarah Linn Buhl Long 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia J. Buhl/wife 473 Thames St. Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Indiantown Gap Cemetery June 8 4 ☐ Donation 5 ☐ Other (Specify) Indiantown Gap. PA 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Douglas A. Fiery Funeral Home 1331 Eastern Blvd, N. Hagerstown, Maryland 21742 Kury Muclas 23a. Part1. Enter the discase, or complications that the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fahore. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 6/10b/aston 9mth /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last attending physicien and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 □ Pregnant at time of death 5 Other (specify) the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 X No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 1 Yes 2 No Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smithsbury mo 229// Je 31. Date filed (Month; Day, Year) Just 32 Registrar's Signature State JUN 09 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			1 - For State Registrar	State of Ma	aryland / Depa <i>Cel</i>	artment of H rtificate of			jiene ⊛g. NØ A ∩ I.	00000
			Decedent's Name (First, Middle, La	st)		timouto or	Douin	2. Date of Dea	th CUU	3. Time of Death
	Physici		Robert Lee Ba	llontino				Month June	Day Year 6, 200	4 12:40AM
	/Medic Examir		4a. Facility Name (If not institution, giv			4b. City, Town, o	or Location of Death		4c. County of Dea	
			Coffman Nursin	ng Home			erstown		Washin	gton County
	Funeral		Social Security Number 6. 5	6ex 7. Age	e (In yrs. last birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day	Year) 9. Bir	thplace (State or Foreign ountry)
	Director		219-14-9303 Usual Residence of Decedent		80 Yrs.			March	15, 1924 1	Maryland
	land		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Marylan -f show lied at	to	Maryland Washin	aton	Hagers	town				1 ☐ Yes 2X No
	r 28a	Director	10e. Street and Number	50011		10f. Zip Code		1	0g. Citizen of What Co	ountry?
	h with	a D	311 Chartridge D	rive		217	42		U.S.A.	
	deat deat	Funeral	11. Marital Status	12. Was Decedent I	Ever in U.S. 13.	Was Decedent of H	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race - Ame Black, Whi	
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mentat Hygiene. If item 27 is marked other then "naturel", or Items 23e or 28a-f show or other treumetic event, the Medical Examinar must be notified at	by	1 ☐ Never Married 3万 Married 3 ☐ Widowed 4 ☐ Divorced	1X Yes 2 □ N If Yes, Give Year or Dates:	10	1 ☐ Yes 2 No		Thous, oto.,	Specify: Wh	
2-0	72 ho	Completed	15. Decedent's E (Specify only highest gra	ducation	16a. Dece	dent's Usual Occup	pation	ring	16b. Kind of Business	/Industry
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and	be fi	Be	17. Father's Name (First, Middle, Last Harper Ballent					e (First, Middle, 1 et Wagam	Maiden Sumame) an	
3	2 should be filed within and Mental Hygiene. Is marked other then eumetic event, the Mental Eumetic event.	²	19a. Informant's Name/Relationship (10h Mailie	a Address /Ctract		<u>-</u>	, City or Town, State,	7-0-4-1
Maryland	d 2 st th and 7 Is r treur		Betty Brenner Ba						, Maryland	
	1 and Health Iem 27 other tr		20a. Method of Disposition	TIENCINE/W	20b. Place of Dispo	sition (Name of			20c. Location - City or	
no	Pages nent of I int: If its iry or o		1 XBurial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Special			matory or other pla	ery June		Hagerstown	
Baltimore,			21. Signature of Funeral Service Lice						Fiery Fun	
B	permit. Departr Importe any inji		1 Junolon L	VIIII	13	31 Faste	rn Blvd.	ugias A. N. Hager	stown, Mar	yland 21742
			23a. Parti. Enter the disease, or comshock, or heart failure. List only	plications that caused	the death. Do not aint					Approximate Interval Between
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	/Medical		resulting in death)	a. Due to (or as	a consequence of	9,0		110		3
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68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit				, , , , , , ,					
687	ifficate g phys as the	edical		_ d						
Вох	attending for use a		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		7 ·			23d. Date of de	ivery
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	res tha signed I be det	by P	Part II. Dther significant conditions	contributing to death bu	ut not resulting in the un	nderlying cause giv	ven in Part I.	23e. Did tob	pacco use contributor	the cause of death?
Records,	w require been signature	ted	_ Cacae	wing	Much	/		1 🗆 Ye	es 2 em 3 Pr	obably 4 Unknown
ecc	e law re has be je 2 sh	Completed						24a. Was a		stopsy findings available completion of cause of
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Vital	Physicien: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?				26. Place of Deat	h (Check only on	θ)	
of V	Shysic this ce al dire	P	1 Yes 2 No	Hospital: 1 Inpatie		t 3 DOA Oth	ner: 4 Fursing Ho	me 5 🗆 Reside	ence 6 Other (Spe	cify)
	ding P h. After t funera	00::	27. Manner → eath 1 → atural 5 □ Pending	28a. Date of Injur (Month, Day	y Year) 28b. Time of Injury	Wor	rk?	28d. Describe ho	w injury occurred	
sio	Attending Ph or death. octor: After th by the funeral	cati	2 Accident investigatio 3 Suicide 6 Could not b				Yes 2 □No			
Division	l or At after d Direct J in by	Certification;	4 Homicide determined		iry - At home, farm, str c. (Specify)	eet, factory, office		28f. Location (St. City or Town	reet and Number or Ru n, State)	ıral Route Number,
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	To the Hospital or Attending within 24 hours after death. To the Funerel Director: Attercompletely filled in by the fune.	Medical	(Check only 2 Medical Examone)	niner: On the basis of and manner sta	examination and/or in	estigation, in my o	ppinion, death occur	ed at the time, da	ate and place, and due	to the cause(s)
	within To th compl	Me	29b. Signature and title of certifier			29c. Licens	se number	29	9d. Date signed (Mont	h, Day, Year)
-	18		SAMUEL UN	(AN, MI)		1)36	65>	J	UNE 7;	2004
	2+1		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type,	Print) II	e ilal	, 11	2 2011	
) '		31 Date filed (Month Par Vace)	30 Call 31	VIJK LOC	1 1/10	KUSTUKK	1 /n/	1 51/4	U
	Sta Registi		31. Date filed (Month, Day, Year)	2004 32. Rigistra	ar's Signature	oute				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Yeer **Physician** June 9, Lucille Caldwell Bartlett 2004 4:20 p /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Laurel Regional Hospital Prince George's Laurel If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Birthplece (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1 □ M 2 1 F 87 1916 Kentucky 215-82-1486 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 28a-f show the Medical Examiner must be notified at 1 X Yes 2 □ No Prince George's Greenbelt Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō 20770 U.S.A. Items 23a 8D Southway death Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examens 1 ☐ Yes 2 XNo 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White If Yes, Give Year or Dates: Completed by 3 X Widowed 4 Divorced Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Caldwell William Lillie May Costello James ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S. Lee Carroll - Son-In-Law 20770 8D Southway, Greenbelt, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 06/12/2004 Brentwood, Maryland Fort Lincoln Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signature of Funeral Service Licensee ODC B. 4739 Baltimore Avenue, Hyattsville, MD 20781 Lanning 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Pneumonia 1 Day Pnysician resulting in death) /Medical Due to (or as a consequence of): Examiner Arteriosclerotic Cardiovascular Disease 3+ Years Sequentially list conditions, lary leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit the attending physician and Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Year Month Dav 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à should be Dehydration 1 ☐ Yes 2 🗓 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Possible Sepsis has page 2 autopsy performed? certificate 1 Yes 1 Yes 2 No 2]X) No or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 X No 1 Inpatient 2 X ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Injury at Work? After 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 2 Accident investigation the 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 1 4 Homicide filled 1 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified D24721 June 10, 2004

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

31. Date filed (Month, Day, Year)

JUN 1 1 2004

R. Registrar's Signature

Syed Sadiq, M.D., 16333 Laurel Bowie Road, Laurel, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Stete Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death _Month **Physician** Year ERNESTINE W. BROWN /Medical 200 4 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner LANHAM PRINCE GEORGE'S DOCTOR'S COMMUNITY HOSPITAL 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10 20 19 9. Birthplace (State or Foreign Days Hours 1 □ M 2 T¥F Yrs. 92 579-20-1240 1911 SOUTH CAROLINA Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits HYATTSVILLE PRINCE GEORGE'S 1X Yes 2 No Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20784 U.S.A. 3731 THORNWOOD ROAD Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No þ 3 X Widowed 4 □ Divorced **BLACK** Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) EXAMINER GOVERNMENT 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be CHRISTOPHER C. WILSON ELIZA WILLIAMS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY E. GRIER/DAUGHTER 3731 THORNWOOD ROAD HYATTSVILLE, MARYLAND 20784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/11/2004 Ft. Lincoln Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER RD. LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown Month Year 4☐ Pregnant at time of death Day 5 Other (specify) Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 200 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed ulcerahas 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 20 No 1 Yes 2 No Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred

The law requires that the death certificate be executed burial-transit Box 68760, physician the esn P.O. of Vital Records, page 2 s director this After Division Hospital or Attending death. after death Diractor: filled in 24 hours a Funaral I

Funeral

Director

al', or Itams 23a or 28a-f show Examiner must be notified at

"natural"

item 27 is marked other than other traumatic event, Ire Ms

= 5 permit. Page Department of Important: If any injury or ance.

Physician

/Medical

Examiner

1 and 2 should be 1 Health and Mental 3

the Maryland

Baltimore, Maryland 21215-0036

completely within 2. To the I State Registrar

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of who completed cause of death (Item 23a) (Type, Print)

5 Pending

investigation

6 Could not be determined

1 Natural

2 Accident

3 Suicide

29a. Certifier

Medicai

4 Homicide

OKNARA 6201 Greenhelt Rel,

0 9 2004

Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

6/8/04

29d. Date signed (Month, Day, Year)

			For	State of Maryland / Depart		ental Hygier	ne	
			For State Registrar		ficate of Death		2004	20242
	Physic /Medi		1. Decedent's Name (First, Middle, Lat	, 299		2. Date of Death Month D	year OLC	3. Time of Death
7	Examir		4a. Facility Name (If not institution, give ANNE XVVILLE	street and number) All Ctv.	b. City, Town, or Location of Death	4	County of Death	rudel
	Funeral Director		5. Social Security Number 6. S 448-30-2529 1	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	9. Birth	place (State or Foreign intry) ahoma
	ryland how		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Local	tion			10d. Inside City Limits
	the Ma	recto	Prince 10e. Street and Number	Georges Bowie	10f. Zip Code	100.0	Citizen of What Cou	1 PYes 2 □ No
	ath with	ral Di	7703 fly		20716		USY	
9800	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23a or 28a-f show may injury or other traumatic avent. The Medical Examiner must be indiffed at ance.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	1 □ Yes 2 TNo	s Decedent of Hispanic Origin? (Spees, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: White	, etc.
21215-0036	within 72 h ene. then "netu he Wedical	npletec	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation 16a. Deceden (Give kin life. DO	it's Usual Occupation of of work done during most of workin NOT use retired)	g 16b.	Kind of Business/In	ndustry
	filed withi Hygiene. other ther ent, the M		1 2		rvisor		Publishi	ing
Maryland	hould be fi d Mental F narked ot natic aver	To Be		Forrest Blagg		(First, Middle, Maide Hammeri	,	
any	2 shoul and Ma is marl aumati	F	19a. Informant's Name/Relationship (7		Address (Street and Number or Rura)			p Code) 21054
	1 and 2 Health a tem 27 i	-		Niece 1111	Flowering Tree	Ct., Ga	ambrills	s, Md.
JOre	Pages 1 nent of H int: If ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	20b. Place of Disposition cemetery, cremate		04	Location - City or To	
Baltimore,	permit. Pag Department Important: I any injury o		*4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Pervice Licen		on Nat'1 Cem. ame and Address of Facility Bea		itland,	
Ä	Depa Impo any in		1000		12 N.W. Crain			
	Pnysician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Conjective Heav	he mode of dying, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death The Parts The Parts
В	Examiner			Due to (or as a consequence of):	y chieve			7 Syear
	pe sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (a) as a consequence of):				
o,	ate be executed hysician and the burial-transit	Examiner	that initiated events resulting in death) Last	c			-	
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.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		topic pregnancy ther (specify)		23d. Date of delive Month	ery Day Year
rds, P.	v requires that been signed b should be dete	by	Part II. Other significant conditions of	ntributing to death but not resulting in the unde	rlying cause given in Part I.		use contribute to the	he cause of death?
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Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:	26. Place of Death	(Check only one)		
of	ding Phys n. After this funeral di	ation; To	1 Yes 2 No 27 Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury		e 5 Residence		ý)
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	To the Hospital or within 24 hours afte To the Funeral Director completely filled in h	Medical C	29a. Certifier (Check only one) Certifying Physics 2 Medical Example 1	sician: To the best of my knowledge, death oc ner: On the basis of examination and/or invest and manner stated.	curred at the time, date and place, ar igation, in my opinion, death occurred	nd due to the cause(s d at the time, date an	i) and manner as sid place, and due to	tated. o the cause(s)
	To th withir To th comp	Ž	29b. Signature and title of certifier	_	29c. License number	29d. Da	ate signed (Month,	Day, Year)
	(2)	+	30 Name and artifact of	omploted source of death flow control	D58733	þ	10104	
2	2		Role Laster	ompleted cause of death (Item 23a) (Type, Prin (KvdW lyfe) ASOUT	his zooz Median	2 Parteray	Annalis	MD 21401
	Sta Registr		JUN 0 9 2004	32. Registrar's Signature			7.00	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Day Year **Physician** WILLIAM BAKER 28, 2004 MAY /Medical 3:30 PM 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7204 Hylton St. Seat Pleasant Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) **Funeral** Months Days Hours **X**□ M 2□ F Yrs Director 578-32-2778 80 21, 1924 Wash., DC Usual Residence of Decedent with the Marylend 10b. County 10c. City, Town or Location **Phow** 10d. Inside City Limits r than "naturel", or items 23a or 28a-f eho the Medical Examiner must be notified at 1 XYes 2 No Directo Maryland Prince George's Seat Pleasant 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 7204 Hylton St. 20743 deeth v United States Funeral 12. Was Decedent Ever in U,S. Armed Forces 9 / 11/50 1 X Yes 2 No 11/50 If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. flled within 72 hours after 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black ğ 3 ☐ Widowed 4 ☐ Divorced Year or Date 06/12/52 Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12th Storekeeper Private other 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be pamit. Peges 1 and 2 should be i Dapartment of Health and Mental i Important: If item 27 ie merked of Rufus Baker Cora Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) William H. Baker, Jr. - Son 7204 Hylton St., Seat Pleasant, MD 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 6 6/4/2004 Maryland Veterans Cem. Cheltenham, MD 22. Name and Address of Facility Stewart Funeral Home 21. Signature of Funeral Service Licensee 4001 Benning Rd., N.E. Wash., DC 20019 wou 23a. Partí Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical a PULMONARY EMBOLUS Examiner Due to (or es a consequence of): Examine DEEP VENOUS THROMBOSIS certificata be executed ettending physician and for use es tha buriel-trensit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760 RETROPERITONEAL NEOPLASM Physician/Medical Due to (or as e consequence of): signed by the et id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No þ should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed The 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Hospital: Other: 1☐ Yes 2X No ۵ 1 ☐ Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🕅 Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation death. 1 Yes 2 No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) fillad in by 4 Homicide To the Hospital within 24 hours e To the Funerel E 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the best of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. cal completaly (Check only 8 one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) D0054344 JUNE 3, 2004 nu 30. Name and address of person who completed cause of death (Itam 23a) (Type, Print) MELISSA TURNER, M.D., VAMC, 50 IRVING ST.N.W., WASHINGTON, DC 20422/688 31. Dete filed (Month, Dey, Year) 2. Registrer's Signature State JUN 0 7 2004 Registrar

DHMH 16 Rev 6/95

ORIGINAL

			For State Registrar	State of M	laryland		rtment of		ind Mental H		004	20244
300	Physici		1. Decedent's Name (First, Middle ROBERT	B.	מ	BROWN			2. Date of D Month MAY 2	Death Day	004 Yeer	3. Time of Death 4:01 a M
1	/Medic Examin		4a. Facility Name (If not institution			NOWN	4b. City, Town,	or Location o			County of Death	
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	ow ow		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
	e-fsh	ctor	MD MONGO	MERY	SI	LVER	SPRING					1 XYes 2 □ No
	ath with the Marylan 23a or 28e-f show ust be notified at	Director	10e. Street and Number 8811 COLESV	TITE DOAD	#02	6	10f. Zip Code			10g. Citiz	ten of What Cou	•
	leath v	Funeral	11. Marital Status	12. Was Deceden	t Ever in U.		1	910 Hispanic Orio	in? (Specify Yes or N	VO- 1	4. Race - Ameri	
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d 2	Hyg The	a)	17. Father's Name (First, Middle,	Last)	-			18. Mothe	r's Name (First, Midd	le, Maiden	Sumame)	
/lan	should be nd Mental marked o	To B	FRANK	BROV	N			MAR	GIE	JO	NES	
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	1 and Health am 27 Ither t		ANDREA JOHNS 20a. Method of Disposition	ON - NIECH					DRIVE,		H LAS	VEGAS, NV
nor	0 0		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S				sition (Name of natory or other pl .ANS CE		06-08-04			M, MARYLAN
Baltimore,	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service		λ	22	. Name and Add	ress of Facility	IMILOR	S FUI	NERAL I	
>	Physician /Medical		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	complications that cause only one cause in each a. Conges Due to (or a	_{line.} stive	n. Do not ente	er the mode of dy	ring, such as			WASII	Approximate Interval Between Onset and Death
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Division	- e - C	Certification	2 Accident investig 3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of Ir	njury - At ho etc. (Specify	me, farm, stre	eet, factory, office		28f. Location	(Street and own, State)	Number or Run	al Route Number,
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		For State Registrar	State of Maryland		rtment of H tificate of L			iene eg. No? () () ()	20245
Physic		1. Decedent's Name (First, Middle, Last) Ethel	О. В	rown			2. Date of Death Month June	Day Year 5, 2004	3. Time of Death 4 12:15 PM
/Med Exam		4a. Facility Name (If not institution, give st Calvert Memoria	reet and number) 1 Hospital		4b. City, Town, or Prince	Location of Death Frederi		4c. County of Dea	
Funera Directo		5. Social Security Number 6. Sex 214-28-3851 1□	7. Age (In yrs. Ia 88	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	3. Date of Birth June 4	, 1916 Mar	thplace (State or Foreign ountry) ryland
anyland show	or	Usual Residence of Decedent 10a. State 10b. County Maryland Calve		Town or Lo	cation esapeake	Beach			10d. Inside City Limits 1 Tes 2 No
with the M Sa or 28e-f	Funeral Director	10e. Street and Number 3612 Dory Brook		011	10f. Zip Code	732	1:	0g. Citizen of What C	ountry?
pennit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other treumatic event, the Modeal Examinar must be multipled at	by Funera	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 ∐Yes 2 ∭No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 🛣 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Am Black, Whi Specify: B	te, etc.
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d be filed w antal Hygier ced other th	To Be Col	10 17. Father's Name (First, Middle, Last) Rufus	Sm	ith	Justice		ne (First, Middle, M	Maiden Sumame) Dixon	
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permit. Departr Importe any inj		21. Signature of Funeral Service License Dlacky C. 23a, Part 1. Enter the disease, or compli	Sewell	14	451 Dare	s Beach	n Rd. Pi		ome ed.,MD20678 Approximate
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DIVISION To the Hospitel or Attending, within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical C	29a. Certifier Certifying Physical Exemination (Check only one)	slcien: To the best of my knowner: On the basis of examinat and manner stated.	wledge, dea tion and/or in	ivestigation, in my	pinion, death occu	urred at the time, d	ate and place, and du	ue to the cause(s)
To ti withii To ti	W	29b. Signature and title of certifier	MO		29c. Licens	502	90		- 04
1		30. Name and address of person who or	=1.4h 110	41031	> RD		na f	rednien	MD 20678
Regi	State strar	31. Date filed (Month, Day, Year) JUN 0	32. Registras Signal	d K	porte				

George Brewster 04-03890 RPD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

)		•	For State Registrar	State of Ma	ryland / Depa <i>Cei</i>	artment of H rtificate of I			giene nog. n2. () () (,	20246
	Physici		Decedent's Name (First, Middle, Last) George Pa	ul Brews	ster			2. Date of Dea Month June 1	3, 2004 Year	3. Time of Death 0430 A M
	/Medic Examin		4a. Facility Name (If not institution, give Route 765 @ Coste	street and number)		4b. City, Town, or Lusby	r Location of Death	<u> </u>	4c. County of Death	1.010
	Funeral		5. Social Security Number 6. Sec	7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl	9. Birtho	place (State or Foreign
	Director		595 24 9231 x Usual Residence of Decedent	^{1M 2□F} 21	Yrs.			May 15	1983 F101	rida
	with the Maryland is or 28s-f show	tor	10a. State 10b. County Maryland Calver	t	10c. City, Town or Lo	_				1 ☐ Yes 2 ☐Xo
	th with the 23s or 28s	il Director	10e. Street and Number 7101 Bond Stree	t		10f. Zip Code 2068	35		10g. Citizen of What Cou United S	
920	or Iteme	by Funeral	11. Marital Status 1 XNever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 □ Yes 2 ☑ N If Yes, Give Year or Dates:	0	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ №	ispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: wh:	etc.
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If Item 27 Is marked other then "natural; any injury or other treumatic event, I're M. dical Ex. 2016.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give	DO NOT use retired	during most of work.		16b. Kind of Business/In	dustry
1d 2	e filled v Il Hygie other i	Be Co	12 17. Father's Name (First, Middle, Last)	2	Sti	ıdent	18. Mother's Name		college Maiden Sumame)	
Maryland	should be find Mental Is marked of	ToE		ster	10h Maili	Address (Ctross		na Pre		Code
	nd 2 sh alth and 27 Is n		19a. Informant's Name/Relationship (Ty Albert Brewster						r, City or Town, State, Zip. MD 20685	Code)
altimore,	Pages 1 and of Hecant. If Item		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ 14 ☐ Donation 5 ☐ Other (Specify)	emoval from State	20b. Place of Dispo competery, crei Arlingto	sition (Name of matory or other place on Natio	Tuly Cem	Ž004 eteryA	20c. Location - City or To rlington	own, State Virginia
Balt	permit. Departr Imports any inj		21. Signature of Funeral Service Licens	DCL		2. Name and Addres	Ra nes Is.	rd. Po	uneral Hor	
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ı	/Medical Examiner			Due to (or as a	consequence of):]					
-3	cuted nd nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence of):					
8760,	icate be executed physician and the burial-transit	edical Exa	resulting in death) Last	Due to (or as a	consequence of):					
P.O. Box 6	ne death certifi the attending thed for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 Live birth 2 4 Pregnant at 1 9 Unknown	2 Fetal death 3	Ectopic pregnancy	1		23d. Date of delive Month	ery Day Year
	quires that the signed by	by	Part II. Other significant conditions co.	ntributing to death bu	t not resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribute to the	ne cause of death?
l Records,	The law requirate has been si page 2 should to	Completed						24a. Was autop perfor 1X Yes	sv prior to co	psy findings available impletion of cause of
of Vital	ysiclan: The is certificate hidirector, page	Be	25. Was case referred to medical examiner?	fospital:	4 C EDIO 111	Oth	26. Place of Death	***		21.0
υof	ding Phys h. After this funeral di	on: To	1 X Yes 2 No 27. Manner of Death 1 Natural 5 Pending	1 Inpatier 28a. Date of Injun (Nonth, ay	28b. Time o				ence 6X10ther (Specification) ow injury occurred	WAT Scene
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	To the Hospital or Attan within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical			examination and/or in				ause(s) and manner as s date and place, and due to	
	To the within To the	Me	29b. Signature and title of certifier	1 8/	-	29c. Licens		4	29d. Date signed (Month,	Day, Year)
			30. Name and address of person who co	ompleted cause of de	ath (Item 23a) (Type	O.C.	M.E.		June 13, 20	004
_	6		JACK M. 1	Trus MID	11		reet, Bal	Ltimore,	Maryland 2	1201
	Sta Regist		31. Date filed (Month, Day, Year) JUN 1	32. Registr	s Signature	but				

			-	State of Maryla				nd Mental H		Legible.		
		•	For State Registrar	oraro or maryran		rtificate of		,	Reg. No.	2004	20247	
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	hysici: /Medic		DALE CLARKSO	N BROOKS				6		2004	1750 M	
F.	xamin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town,		Death	1	County of Death		
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D			Usual Residence of Decedent					0/11/	1521			_
arylar	ahow id at	-	10a. State 10b. County		ity, Town or Lo						10d. Inside City Limits X☐Yes 2☐No	
the M	28a-f	Director	MD Worces 10e. Street and Number	ter	Ocea	n Pines			10a Citi	zen of What Cou		
1215-0036 within 72 hours after death with the Maryland ene.	ed other then "natural", or items 23s or 28s-1 show event, the Medical Expression match be notified at	급	135 Sandyhook	RD		2181	1				inti y r	
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affer G	or Ite		1 Never Married 2 Married	Amed Forces? 1 ☐ Yes 2 No If Yes, Give		1 Tes, specify Cub 1 ☐ Yes 2 X No		ruento Hican, etc.)	ŀ	Black, White, Specify: Wh		
21215-0036 d within 72 hours af giene.	ural.	d by	3 XWidowed 4 □ Divorced	Year or Dates:								_
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be filed tal Hygi	vent,	Bec	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middle	, Maiden	Sumame)		
aryla:	marked matic ev	To	George Clarks	son			L	ie McCaul				
Maryland d 2 should be file th and Mental Hy	item 27 is marke other traumatic		19a. Informant's Name/Relationship (7) Sherwood Broom					or Rural Route Numb			o Code)	
C = '	em 2		20a. Method of Disposition			sition (Name of natory or other pla		n City, M		1843 cation - City or To	own. State	_
MOF Pages Tent of	= 5		1 Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specify	Temoval nom State		natory or other pla Cemetery	_	/11/04		shohock		
Baltimore, permit. Pages 1 ar Department of Hea	important: If any injury or once.	Ī	21. Signature of Funeral Service Licen					e Burbag				-
n að.	any ir		Tarrueline	J. Nab	kette	108 Willi	am St.	Berlin,	MD 2	11811 21811	ome	
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-15	dical miner		resulting in death)	Du to or as a conse	quence of):	04 5	-					
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death certifical	ng ph e as th	Med	IF FEMALE:	0					1			
BOX eath cer	attending pl	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1□Live birth 2□Fet	al death 3	Ectopic pregnanc	у		2	3d. Date of delive Month	ery Day Year	
	by the a	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□ Pregnant at time of a 9□ Unknown	death 5∟	Other (specify) _						
- 2	igned by	y Ph	Part II. Other significant conditions co	ntributing to death but not re	sulting in the ur	nderlying cause giv	ven in Part I.	23e. Did	tobacco us	se contribute to the	he cause of death?	
Records,	should be	ed by							Yes 2□	2 No 3 Probably 4 ☑ Unknown		
S ¥ .		Completed						24a. Was		24b. Were auto	psy findings available	_
	ate h page	Com						— auto perfe 1 ☐ Yes	ormed?	death?	mpletion of cause of 2□ No	
Vital	this certificate al director, pag	Be (25. Was case referred to medical examiner?					Death (Check only	one)			-
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DIVISION If or Attending after death.	Director:	fical	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At h	ome, farm, str				28f. Location (Street and Number or Rural Route Number,			-
al or safter	d in b	Certification;	4 Homicide	building, etc. (Speci	(fy)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or To	wn, State)		,	
ospit	unera ily fille		29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	sician: To the best of my kniner: On the basis of examina	owiedge, death	occurred at the til	me, date and p	place, and due to the	cause(s)	and manner as si	tated.	_
To the Hospital within 24 hours	To the Funeral Direct completely filled in by	Medical	one)	and manner stated.	attor and/or in	restigation, in my c	ppinion, death o	occurred at the time,	date and	place, and due to	the cause(s)	
5 <u>§</u> 1	200	~	29b. Signature and title of certifier							Date signed (Month, Day, Year)		
		}	30. Name and address of person w o	moleted cause of death (%)	m 23a) /T	DUU Print)	605	25	Jun	28 20	04	
जा।	3		Nadia Angov.			,	Rarlin	MD 2181	1			
	Sta		31. Date filed (Morth, Day, Year)	32 / legistrar's Sign	ature	ay Dr. C	ermi,	MD 2181				
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DHMH 17 Rev 1/2001

6/17/1924-6/8/2004

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 6Day June 2004 0930 **Physician** Leroy Bowman /Medical 4c. County of Death 4h City Town or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel 1949 Forest Dr. Annapolis | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Y June 18 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Year) Virginia 94 Yrs. 216-44-2804 XXM 2 F June 1909 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d, inside City Limits 10a. State ii Hygiene. other then "natural", or Itams 23e or 28a-f ehow vent, the Medical Examiner mast be notified at 1X Yes 2 □ No Marvland Anne Arundel Annapolis Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 21401 USA 1949 Forest Dr. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after 1 ∏ Yes 2 [X]No If Yes, Give Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2♥ No Specify: Black 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) First Baptist Church 12th 2yrs Pastor 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Importent: If Item 27 ie marked other any injury or other treumatic event. 17. Father's Name (First, Middle, Last) James Bowman Lucille Alexander 2 19a. Informant's Name/Relationship (Type, Print)
Marcia Wooden (Niece) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 905 Booker Dr. Capitol Heights, Md. 20743 H1 Length Common Grand Care at 6-11-0420c. Location - City or Town, State 20a. Method of Disposition XXBurial 2 Cremation 3 Removal from State Annapolis, Md. Cemetery 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Wm. Reese Sons Mortuary, P.A. Larry & Reese 1100483 821 West St. Annapolis, Md. 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ento who Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as aconsequence of): Examiner attending physician and for use as the burial-transit death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 4☐ Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No P.O. 1 the 9☐ Unknown signed by d 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Nown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No after death.

Director: After this certifice 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA ပို 1 ☐ Yes 2 No 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) funeral 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Injury 1 Natural 2 Accident 5 ☐ Pending 1 TYes 2 No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral L t 📆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier D 46303 leted c se of death (Item 23a) (Type, Print) 30. Name and address of person who 2002 Marical Phy Suite 310, Annapolis, M.) METTA DR. MARLO A. 32. Regi State Registrar

Amended Item #8
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 6-8-04/Per FH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth **Physician** 2004 Year Jimmy Lee BENNER June 5, 4:45 a.m. /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 223 North Mulberry Street Washington Hagerstown If Under 24 Hrs. 5. Social Security Number If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) **Funeral** Months Days Hours 1⊠M 2□ F 219-46-1188 Yrs. 57 Director Oct. 12,1946 Maryland Usual Residence of Decedent August 12, 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits Director Maryland Washington 1⊠ Yes 2 No Hagerstown 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 223 North Mulberry Street 21740 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. filed within 72 hours efter 1 ☐ Yes 2 ☒ No If Yes, Give 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0020 ò 1 Yes 2 No Specify: white Completed by 3 Widowed 4 Divorced Yeer or Detes: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Peges 1 end 2 should be filed within nent of Health end Mentel Hygiene. int: If Itam 27 ia marked other than Elementary/Secondary (0-12) College (1-4or 5+) truck driver furniture manufacture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Benner Dorothy Moser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) of Health e Gloria Benner - wife 223 North Mulberry Street, Hagerstown, Maryland 2174 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 St Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Lawn Memorial Park 2004 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland 21. Signalure of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part1. Enter the diseese, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a con by Physician/Medical Examiner The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco, use contribute to the cause of death? 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 20 No Other: 1 Tes 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 □Other (Specify) this 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) Certification: 28b. Time of 28c. 28d. Describe how injury occurred Injury et Work? 1 Natural 2 ☐ Accident 5 Pending investigation To the Hospital or Attending within 24 hours after deeth.

To the Funeral Director: Aft completely filled in by the fur 1 Tes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide edical 29a. Certifier Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as a subsection of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29b. Signature end title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) 2004

Registrar

10

State

30. Neme and address of person who

completed cause of death (Item 23a) (Type, Print)

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113

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day Yeer Month **Physician** Barbara LaRue Collins 0305 June 2004 11 /Medical 4c. County of Deeth 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Talbot Easton Talbot Hospice House | If Under 1 Year | If Under 24 Hrs. | B. Date of Birth (Month, Day, Year) | O 6 / 1 7 / 42 Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** 1 □ M 2 □ F 61 Yrs. Pennsylvania 173-34-7795 **Director** Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Exacultar must be notified at any injury or other traumatic event, the Medical Exacultar must be notified at any injury or other traumatic event. 10a. State 10b. County Federalsburg 1 ☐ Yes 2 🛣 No MD Caroline Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Peges 1 and 2 should be filed within 72 hours after death with United States 21632 24541 Hynson Road 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: δ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Convenience Store Cashier 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Grace Rowe George Leberman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 24541 Hynson Rd., Federalsburg, MD 21632 Robert A. Collins/Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Hillcrest Cemetery 6/15/04 Federalsburg, MD 22. Name and Address of Facility Framptom Funeral Home, P.A. 216 N. Main St., Federalsburg, MD 21632 21. Signature of Funeral Service Licensee 7. Eskow Michael 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Endo moto **Physician** disease or condition resulting in death) lo month /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 Other (specify) ed by the detached P.O. 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t Certification: the Hospitei or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 30. Name and address of Jerson who completed cause of death (Item 23a) (Type, Print) Easton MD 21601 Deshields 11. D. Ave. 509 Idlewild Mary 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Physici	an.	1 - State Registrar6-15-04, per FHDR, 1 Decedent's Name (First, Middle, Last)	HOHD, al Ce	rtificate of Death	2. Date of Death Month	NoC U U 3 3. Time of Death
/Medic Examir	al	Cathy K. Campbell 4a. Facility Name (If not institution, give street and Union Memorial Hospita		4b. City, Town, or Location of Dea	June n	10 200 0505 A 4c. County of Death
Funeral Director		5. \$220 \(\text{94} \) \(\text{4616} \) Usual Residence of Decedent	7. Age (In yrs. last birthday)	Baltimore City If Under 1 Year If Under 24 Hrs Months Days Hours Min	. (Month, Day, Yea	9. Birthplace (State of Fra Country) INDIA 8, 1950 Oakland C
s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mentat Hygiene. Item 27 Is marked other than "naturel", or ftems 23s or 28s-f show other traumettic event, the Medical Examiner mant be notified at	ctor	10a. State 10b. County MD Frederick	10c. City, Town or Lo			10d. Inside City Limi 1 ☐ Yes 2☐ I
	rai Director	100. Street and Number 10029 Four Points Ro	ad	10f. Zip Code 21778	10g. (Citizen of Whal Country?
	by Funeral	1 Never Married X2 Married 1 1 If Ye	Yes X No	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puel 1 ☐ Yes 2 🎛 No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
within 72 ho ene. than "natur ne Madical	Completed	15. Decedent's Education (Specify only highest grade completion of the completion of	(Give life.	dent's Usual Occupation kind of work done during most of wo DO NOT use retired)	rking 16b.	Kind of Business/Industry Real Estate
uld be filed v lental Hygie ked other t ilc event, III	To Be Co	17. Father's Name (First, Middle, Last) Willard P. Campbe		18. Mother's Na	me (First, Middle, Maid McCrea	
1 and 2 should Health and Men Iem 27 Is marke other traumatic		19a. Informant's Name/Relationship (Type, Print Arthur D. Baker, Hus		ng Address (Street and Number or R 1029 Four Points		y or Town, State, Zip Code) Ridge, MD, 21778
Page nent o ant: If ary or		20a. Method of Disposition 1 ☐ Burial 2 ☐ Gremation 3 ☐ Removal 1 ☐ Donation 5 ☐ Other (Specify)	from State 20b. Place of Disposition State W. Arunde	sistion (Name of natory or other place) 21 Crematory	ne 12, 2004 Od	Location - City or Town, State
Departr Departr Imports any inju		21. Signature of Funeral Service Licensee Living L. Hutth 23a. Part. Enter the disease, or complications shock, or heart failure. List only one cause	1.101201 B	Name and Address of Facility Connections Home Bremations Heckro	tte. P.A. C	P.O. Box 784
Physician /Medical /Medical Examiner / Lausit /	dicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events C	A	culer eccio	A .	Interval Between Onset and Death Once elacu
e death certificate the attending physic	Physician/Med	in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
quires that the de in signed by the a uld be detached t	þ	Part II. Other significant conditions contributing	to death but not resulting in the u	nderlying cause given in Part I.		o use contribute to the cause of death? 2 ☑No 3 ☐ Probably 4 ☐Unknow
Attending Physician: The taw requires that the death certifical ordath. ir death. ector: Afler this certificate has been signed by the attending phy the funeral director. page 2 should be detached for use as the	Completed				24a. Was an autopsy performed?	
	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 27. Manner of Death 1 Aulural 5 Pending 2 Accident investigation	1 ☑Inpatient 2 ☐ ER/Outpatien Date of Injury Month, Day Year) 28b. Time of Injury		5 □Other (Specify) y occurred	
i di it o	Certification;	4 Homicide	Place of Injury - At home, farm, str building, etc. (Specify)		and Number or Rural Route Number, ite)	
within 24 hours after To the Funeral Direction	Medical	one) 2 Medical Examiner: On	manner stated.	n occurred at the time, date and place vestigation, in my opinion, death occurred to the control of the control	irred at the time, date a	nd place, and due to the cause(s)
Veril To Con	_	29b. Signature and title of certifier Doccelyne Kousethches 30. Name and address of person who completed TOCELYNE KOURTCHO	I, MD	AT ZU 3 80	29d. Dun	oate signed (Month, Day, Year) ne nine 2004
		30. Name and address of person who completed	cause of death (Item 23a) (Type,	University Park	way Bal	timore my 2121

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Ragistrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 830 AM AU SOON 00 2004 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Mony 9. Birthplace (State or Country) Silver \aleph c OTING AMARAC 13107 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (În yrs. last birthday) 1)20 M 2□ F Months C Yrs. None Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. Count 10d. Inside City Limits 1 ☐ Yes 2 No ND omerc 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 00 th 209 13107 A 12. Was Decedent Ev. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ້ຳ ປ.ຣ 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seçondary (0-12) College (1-4or 5+) NONE NONE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Soo SUNG YUNG 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Na e/Relationship (Type, Print) 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 □Donation 5 □ Other (Specify) RRIVA 22. Name and Address of Facility 21. Signature of Fyneral Service Licensee Bell Service 4902 STANHAVEN TEMPLE HILLS MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) AATERIC SCURO TIC CHRONOUNSZULTAL DISPLASE Due to (or as a consequence of): Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2[] No 1 ☐ Yes 2 🕅 No 1 TYes 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) examiner? Hospital:

Physician /Medical Examiner

requires that the death certificate be executad

this certificate has

within 24 hours a

Division of Vital Records, P.O. Box 68760

Physician

/Medical

Examiner

Funeral

Director

r than "naturel", or Items 23a or 28a-f show The Modical Examinary ust be notified at

filed within 72 hours after

at Hygiena.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any jury or other traumatic svent 20xe.

Baltimore, Maryland 21215-0036

Directo

Funeral

þ

Completed

Examine cate has been signed by the attending physician and page 2 should be detachad for use as the burial-transit Physician/Medical þ Completed us after death.
urs after death.
ureal Director: After this certinumeral Director, pr Be Certification: filled in by the

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Other: 4 Nursing Home 5 esidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred

28a. Date of Injury (Month, Day Year)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

5 Pending

investigation

6 Could not be determined

29c. License number 015236 29d. Date signed (Month, Day, Year)

fool of suit

Rockvius MO 20852

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11125 POCKLING PIE ARL I. WHACOUS

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State Registrar

2004

27. Manner of Death

1 Natural

2 Accident

3 Suicide

(Check only one)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No) 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** JACOUELINE CRAWFORD W. JUNE 2004 11:45a /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 11434 WAESCHE DRIVE MITCHELLVILLE PRINCE GEORGES 8. Date of Birth
JUNE 30, 1923 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)

WASH.DC 5. Social Security Number 7. Age (In vrs. last birthday) Funeral Days 1□M **3**(□F Months Hours Min. 80 Director 578-26-1297 Usual Residence of Decedent 10c. City Town or Location 10a State 10b County 10d. Inside City Limits 28a-f show other traumatic event, If a Mudical Exertiner rust be nutified at 1 ☐ Yes 2 ☐ No Director DC WASHINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2110 4th STREET, NE 20001 U.S.A. or Items 23a Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 14. Race - American Indian. 11 Marital Status o filed within 72 hours after deal Hygiene. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced BLACK Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 1 2 T H College (1-4or 5+) COMMUNICATION COMMERCE DEPARTMENT d 2 should be filed with and Mental Hygie 7 is marked other ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be HORACE R. CRAWFORD BESSIE SCOTT ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st. Department of Health and Important: If item 27 is many injury or other traum GERTRUDE HEBRON -GODDAUGHTER 11434 WAESCHE DR., MITCHELLVILLE, MD Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State MT.OLIVET CEM. 6-08-04 WASHINGTON, DC 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility TAYLOR'S FUNERAL HOME 21. Signature of Funeral Service 1722 NORTH CAPITOL ST., NW WASH. DC 20001 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician a Metastatic Adenocarcinoma of the Breast /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated as enter Due to (or as a consequence of) Examiner certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): physician Box 68760, Physician/Medical the IF FEMALE Se si 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan autopsy performed? 2 🙀 No 1 Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 Σ Other (Specify) GoddaughtHospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 2 1 🗌 Yes 2X□ No 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: After Residence 5 Pending investigation 1X Natural death. 1 Yes 2 🗆 No 2 Accident after death 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Funeral 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Siwek - 4151 Bladensburg Road, Colmar Manor, 20722 31. Date filed (Month, Day, Year) State JUN 0 7 2004

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 21:15 PM 2004 June Hancock /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Prince George's Fort Washington Fort Washington Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ₩ 2 □ F 244-52-9934 Yrs 30 1936 North Carolina 67 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State "natural", or Itams 23a or 28a-f show adical Examinar must be notified at 1√PYes 2 No Fort Washington Prince George's Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20744 U.S.A. 8611 Kult Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. n ⊠Yes 2□No Air If Yes, Give Year or Dates: Force 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No Specify **Black** þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) House Keeping Supervisor 10th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Lillian Worthington Roosevelt Coley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8611 Kult Lane Fort Washington, Maryland Helen Y. Coley/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 6/7/2004 Maryland Veteran's Cheltenham, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility J. B. Jenkins Funeral Home 21. Signature of Funeral Service Licenses 7474 Landover Road Landover, Maryland 20785 D. Mai فادنه 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARDIO ULMONARY Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year for in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ pe 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an certificate has autopsy performed 1 Yes 2€ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗌 Yes 2 No 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after deat To the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide ō To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Irad; Sadeghian M.D. 6301 Oxonhill Rd # 301 Oxonhill, Maryland 20745 31. Date filed (Month, Day, Year) 2. Registrar's Signature State JUN 0 7 2004 Registrar

ORIGINAL

			-	•	adment of Leeth and M	•	_	
			For State	•	partment of Health and Mertificate of Death	_	0001	20055
			Registrar	CE	entificate of Death	Reg. 2. Date of Death	No.	3. Time of Death
	Physicia	an	Decedent's Name (First, Middle, Last)	7.1.7.7		Month	Day Year	3. Time of Death
	/Medic	al	Marguerite Cathering 4a. Fecility Name (If not institution, give str		4b. City, Town, or Location of Death	June	7 2004 4c. County of Death	
	Examin	er					Washingt	
	Francis		Washington County F 5. Social Security Number 6. Sex	7. Age (In yrs. last birthday	Hagerstown // If Under 1 Year If Under 24 Hrs.	8. Date of Birth		nplace (State or Foreign untry)
	Funeral Director			^{1 2} ∑F 86 Yrs.	Months Days Hours Min.	(Month, Day, Ye April 13	1918 Ne	w York
			Usual Residence of Decedent					
	inylan show	_	10a. State 10b. County	10c. City, Town or L	Location			10d. Inside City Limits 1 ☐ Yes 2 No
	Ba-f s	ct	Maryland Washingto	on Willi	lamsport			
	vith th	Director	10e. Street and Number		10f. Zip Code	10g.	. Citizen of What Co	untry?
	s 23s	la l	10631 Peach Tree La		21795	offic Van as Na	U.S.A.	rican Indian
	er de Item	Funeral	11. Marital Status 1 □ Never Married 2 □ Married	. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ▼No	. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F	Rican, etc.)	Black, White	
38	within 72 hours after death with the Maryland ene. than "netural; or Items 23a or 28a-f show the Medical Examinar must be notified at	by	3 XWidowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes X ☐ No Specify:		Specify: Wh	nite
ğ	2 hou		15. Decedent's Educa	tion 16a. Dec	edent's Usual Occupation	161	b. Kind of Business/l	ndustry
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멀	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other than "natural", or ltems 23a or 28a-f show event, the Medical Examinat must be notified at	Be (17. Father's Name (First, Middle, Last)		18. Mother's Name		den Sumame)	
yla	2 should be and Mentai is marked is umartic ev	၉	Unknown		Unkno			
Baltimore, Maryland 21215-0036	d 2 should th and Mer 7 is marke traumatic	4 9	19a. Informant's Name/Relationship (Type		iling Address (Street and Number or Rura		•	
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و	Pages nent of I int: If its iry or o		1 ☐ Burial 2 XCremation 3 ☐ Rer	novarnom State	position (Name of pernatory or other place)			
臣	it. P.		4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service Licensee		own Crematory 6/8/		agerstown, ineral Hom	Maryland
Ba	permit. Pages Department of I Important: If its any injury or o		> SONTH	m	415 E. Wilson Blvd		stown, Md.	
			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	itions that caused the death. Do not e				Approximate
	Physician		Immediate Cause (Final	cause on each line.	1			Interval Between Onset and Death
1	/Medical		disease or condition resulting in death)	Due to (or as a consequence of):				3 ACVS
	Examiner		B. C. C. C. C. C. C. C. C. C. C. C. C. C.	Arto estebiova	scular inferetion.			7 der 5
	P =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):				
	nd trans	Examiner	that initiated events C.					
760,	ie be executed ysician and e burial-transit		resulting in death) Last	Due to (or as a consequence of):				
687	leath certificate b attending physic	dical	d.					
9 x	ding p	Physician/Medi	IF FEMALE: 230	c. If yes, outcome of pregnancy			23d. Date of deli	
Вох	atten for u	cian	in the past 12 months?	1 Live birth 2 ☐ Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)		Month	Day Year
o.	t the de by the a	ysi	1 □ Yes 2 □ No 9 □ Unknown	9☐ Unknown				
4	th de de		Part II. Other significant conditions contr	abuting to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
rds	n sign	ed by	High Blood pressu	119		1 🗆 Yes	2, 2√No 3 □ Pro	obably 4 Unknown
00	aw requir s been si 2 should l	oleto	/			24a. Was an	24b. Were au	topsy findings available
R	The lay	Completed				autopsy performed	d? death?	ompletion of cause of 2 \(\subseteq \text{No} \)
Vital Records,	ilcian: Th certificate rector, pag	BeC	25. Was case referred to medical		26. Place of Death			
of V	id i	70	examiner? 1 Yes 2 No	spital: 1 Inpatient 2 ER/Outpati	ent 3 DOA Other: 4 Nursing Hon	ne 5 🗆 Residenc	e 6 Other (Spec	eify)
0	ng Pl		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year) 28b. Time Injury	Work?	8d. Describe how	injury occurred	
sio	tendi leath. tor: A the fu	catl	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		M 1 Yes 2 No	n/ 1 1' (O)		
Division	or At ifter d Direct in by	Certification:	4 Homicide determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	City or Town, S	at and Number or Ru State)	ral Houte Number,
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funera		29a. Certifier Certifying Physic	rian. To the best of my knowledge, de:	ath occurred at the time, date and place, a	nd due to the caus	co(s) and manner as	stated
	24 hos Fun	edical	(Check only 2 Medicel Examine one)	r: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurre	d at the time, date	and place, and due	to the cause(s)
	ompl	₩	29b. Signature and title of certifier	^	29c. License number		Date signed (Month	, Day, Year)
	. 3 - 0			e mo	0-0056413		6/9/64	/
	774		30. Name and address of person who com	pleted cause of death (Item 23a) (Type	e, Print)			
C	pr.		Dr S. Saxena	3 Byrkit Drive	e, Print) William Syort W	we y land		
	Sta		31. Date filed (Month, Par, Ye 1) 0 20	32. Pagistrar's Signatura	Speck			
	Regist	rair		/				

			State of Maryla	nd / Depa	artment of Healt	th and Mental Hyg	iene	20056
			Registrar	Cei	rtificate of Dea		eg. No. UU4	20200
	Physici /Medi		1. Decedent's Name (First, Middle, Last) Charles Edwin Dowl	er		2. Date of Deat Month	Day Year 2004	·
	Examir	ner	4a. Facility Name (If not institution, give street and number) Washington County Hosp		4b. City, Town, or Locat Hagerstov	wn,	4c. County of Deal	gton
l,	Funeral Director		220-18-2185 1X0M 2CIF 74	s. last birthday) Yrs.	If Under 1 Year If Ur Months Days Hou	nder 24 Hrs. 8. Date of Birth Month, Day, NOV •	9. Bird Co	hplace (State or Foreign untry)
	Maryland f show	or		lear S	cation Spring,			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the la or 28a-	Direct	10e. Street and Number 11608 National Pike		101. Zip Code 21722	10	Og. Citizen of What Co	
920	be filed within 72 hours after death with the Maryland hat Hygiene. Indicate than "natural", or Itams 23a or 28s-1 show of other than "natural", or Itams 23a or 28s-1 show event, the Modical Exarting must be notified at	by Funeral Director	11. Marital Status 12. Was Decedent Ever in Armed Forces? 1 Never Married 27 Married 1 Types 2 7 No	47-	Mas Decedent of Hispanio f Yes, specify Cuban, Mex 1 ☐ Yes 2 No Spe	c Origin? (Specify Yes or No- kican, Puerto Rican, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.
Maryland 21215-0036	within 72 ho ene. than "natur he Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10th grade 0	(Give	dent's Usual Occupation kind of work done during DO NOT use retired) Cuck drive:	most of working	self emp	,
land 2	ihould be filed within Id Mental Hygiene. marked othar than matic evant, tre Ma	To Be Co	17. Father's Name (First, Middle, Last) Lloyd James Dowler		18. M	other's Name (First, Middle, Milandia, Middle, Milandia,	Maiden Sumame)	
	d 2 s th ar 7 is trau		19a. Informant's Name/Relationship (Type, Print) Charlene Butts daughter	19b. Mailir 1162	ng Address (Street and Nu 28 Ashton I	umber or Rural Route Number, Road Clear S	City or Town, State, Z pring, M	D 21722
Baltimore,	Pages 1 annent of Healt ant: If itam 2 ary or other		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	Place of Dispo cemetery, creat edar I	sition (Name of natory or other place) awn cem.		10c. Location - City or Hagersto	·
Balt	permit. Pages. Department of the important: If its any injury or of once.		21. Ignate Funeral Service Licers 46	г Г Р.	Name and Address of Fo Onald Edw O.BOX 310	in Thompson Clear Sprin	Funeral	Home,Inc 722
760,	/Medical Examiner buysician and street but and stre	Ical Examiner	23a. Pf.a1. Enter the disease, of complications that caused the described in the complex of the complex of the complex of the cause of the complex of the complex of the cause of the complex of the cause of the cau	TITER quence of): PISCULII quence of):	STITIGL FISC		St,	Approximate Interval Between Onset and Death 2 WEKS WEEKS MUTTA
.O. Box 68	The law requires that the death certificate tite has been signed by the attending phy age 2 should be detached for use as the	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnant at time of 9☐ Unknown	tal death 3	Ectopic pregnancy		23d. Date of deliment	very Day Year
rds, P	w requires that been signed b should be deta		Part II. Other significant conditions contributing to death but not re AUTE AFWAL FAILURE; 5		nderlying cause given in Pa	,	acco use contribute to	
Vital Records,		Be Completed by	ATHEROSCIEDROTIC CARNION CHOW SIC OBSTRUCTIVE PULMON 25. Was a referred to medical DION-RHEUM	JARY D	ISBASE. H	24a. Was an autopsy perform YPEATON 1 Yes 2 lace of Death (Check only one	ed? prior to c death? 1 ☐ Yes	opsy findings available ompletion of cause of 2 No
o	ding Phys n. After this funeral di	은	Hospital:	ER/Outpatien 28b. Time of Injury	Other	Nursing Home 5 Residen	ice 6 Other (Spec	rfy)
Division	in Dirt	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At building, etc. (Special Could not be building, etc.)	nome, farm, stre ify)	eet, factory, office	28f. Location (Stre City or Town,	eet and Number or Rui State)	al Route Number,
	To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my kn and manner stated.	owledge, death ation and/or inv	occurred at the time, date restigation, in my opinion,	e and place, and due to the cau death occurred at the time, dat	use(s) and manner as e and place, and due	stated. to the cause(s)
	To the within To the comple	M	29b. Signature and title of certifier)	29c. License numb	per 296	d. Date signed (Month)	Day, Year)
			30. Name and address of person who completed cause of death (Ite	m 23a) (Type, I	Print) SUITE	2/30	619104 NAGERU	POWN,
	Sta	te	31. Date filed (Month, Day, Year) 32. Pegistrar's Sign	//// ature	MESICAL (ANTAUS KD	MD 21	742
	Registr	7	JUN 10 2004 Janeer .	A. Bo	ule			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** Gaynella 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner MONTGOMERY WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Hours Months 1 ☐ M 2 € F 6Ž 17 1941 NORTH CAROLINA Yrs. 237-66-9344 Director Usual Residence of Decedent filed within 72 hours after deeth with the Maryland Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or itame 23a or 28a-f ehow the Medical Examiner must be notified at BRENTWOOD 1 Yes 2 No PRINCE GEORGE'S Director MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20722 U.S.A. 3703 UPSHUR STREET Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Tyes 2 No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Government 4 yrs Inspector permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked othe any injury or other treumatic event, pose. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Arlena Sherrod Clifton Davis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3703 Upshur Street Brentwood, Maryland 20722 19a. Informant's Name/Relationship (Type, Print) Vivian Addison/Friend 3703 Upshur 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 6/9/2004 Cheltenham, Maryland Maryland Veteran's * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. Jenkins Funeral Home 7474 Landover Road Landover, Maryland 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) epatic Tail **Physician** Month /Medical Due to (or as a consequence of): ronodular Cirrhosis Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to for as a consuguence of Examiner The law requires that the death certificate be executed signed by the attending physicien and dbe detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed peeu; 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 24a Wasan has rmed? 2 □ No certificate 1 Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: P 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: After t 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation after death 2 ☐ Accident filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide To the Hospitel o within 24 hours af To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11120 New Hormson Leibowit MIChael . Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 0 9 2004 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

		1	State of Maryland / Dep State of Maryland / Dep Registrer Ce	artment of Health and Nertificate of Death		ene 1. 2004 20258
			Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of Death
П	Physicia Medic		KEVIN JAMES DARBY, JR.		May 31	0731 PM
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
*			Prince George's Hospital Center	Cheverly If Under 1 Year If Under 24 Hrs.	2. Date of Birth	Prince George's
	Funeral		5. Social Security Number 216 15 3424 6. Sex XIX M 2 F 7. Age (In yrs. last birthday 23 rs.)	Months Days Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birthplace (State or Foreign Country) WASHINGTON, DC
	Director		216 15 3424 23**** Usual Residence of Decedent		DEC. 10,	1900 WASHINGTON, DC
	yland yland		10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	e-f st	ctor	MARYLAND PRINCE GEORGES BOWIE			XX Yes 2 No
	or 28	Director	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Country?
	ath w	rail	15009 JORRICK COURT	20721	pacifu Vas or No-	UNITED STATES 14. Race - American Indian,
	er de Items	Funeral	11. Marital Status XX Never Married 2 ☐ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XX No	. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.
38	urs aft	þ	3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes XX No Specify:		Specify: BLACK
21215-0036	within 72 hours after death with the Maryland ene. then "naturel", or Items 23s or 28e-f show he Medical Expirities must be notified at	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of won	king 16	6b. Kind of Business/Industry
2	thin 7	npie	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		
	i filed w I Hygier other th	S	11TH 17. Father's Name (First, Middle, Last)	STUDENT 18 Mother's Name	ne (First, Middle, Ma	aiden Sumame)
Maryland	should be filed within 72 hours after dea nd Mental Hygiene. marked other then "naturel", or Items metic event, the Medical Expriment	Be c			WALLACE	,
Ž	should be nd Mental marked c	은	KEVIN JAMES DARBY, SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mai	ling Address (Street and Number or Ru		City or Town, State, Zip Code)
<u>≅</u>	old 2 shoulth and it is my reference		ANITA McCLINTON / MOTHER 1500	9 JORRICK CT. F	BOWIE, MD	20721
ē,	is 1 and 2 of Health a item 27 is other treu		20a. Method of Disposition 20b. Place of Disposition	position (Name of ematory or other place)	Date 20	Oc. Location - City or Town, State
E	Page nent c ant: If		'XXBurial 2 ☐ Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify) LINCOLN	MEMORIAL CEM. 07 J	IUN 2004	SUITLAND, MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23s or 28e-f show any injury or other treumetic event, the Medical Expanding the positive of other treumetic event, the Medical Expanding the positive of other treumetic event, the Medical Expanding the positive of other treumetic event, the Medical Expanding the positive of the positive of the provided the market of the provided the pr			22. Name and Address of Facility ARSHALL'S FUNERAL 308 SUITLAND ROAD	HOME OF N	MARYLAND, INC. ND, MD 20746
			23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac		t, Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition a Multitue Pure	that Would		Onset and Death
	/Medical		resulting in death) a. The pue to (or a a consequence of):			
	Examiner		Sequentially list conditions, b. Due to (or as a consequence of):			
	ed isit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
	death certificate be executed e attending physician and ed for use as the burial-transit	Examiner	that initiated events c			
8760,	e be e siciar e buria					
9	tificate ig phys as the	ledicai				
Вох	eath certific attending pl	an/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3	□Ectopic pregnancy		23d. Date of delivery Month Day Year
	e deal he att	sicia	in the past 12 months? 1	Other (specify)		
P.0	that the de ted by the a detached	Physic	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?
ds,	uires tha signed l d be det	d by		, ,	1 ☐ Yes	2 □ No 3 □ Probably 4 Ounknown
20	law requires as been sign 2 should be	ete			24a. Was an	24b. Were autopsy findings available
Vital Records,	9 - B	ompiete			autopsy perform	prior to completion of cause of death? No 1 Yes 2 No
tal	ien: Th rtificate	O	25. Was case referred to medical	26. Place of Dea	th (Check only one	
	rysici iis ce direc	To B	examiner? 1 X Yes 2 □ No Hospital: 1 □ Inpatient 2 XER/Outpati	ent 3 DOA Other: 4 Nursing H	lome 5 🗆 Resider	ce 6 Other (Specify)
n of			27. Manner of Death 1 □ Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injury	Work?	28d. Describe how	v injury occurred
Division	leath leath lor: the	Certification:	2 Accident investigation 5/3/64 /847	1 Yes 2 No	28f Location (Stre	eet and Number or Rural Route Number,
Σ	in the	ertifi	3 Suicide Could not be determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)	Street, ractory, office	City or Town,	State) 10609 Wovellaum
7	Hospitel 24 hours a Funerel stely filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge, de	ath occurred at the time, date and place	, and due to the car	use(s) and manner as stated.
)	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edicai	(Check only one) (Check only one) Medicel Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occu	irred at the time, dat	te and place, and due to the cause(s)
	To the Hospitel within 24 hours a To the Funerel Completely filled	Me	29b. Signature and title of certifier	29c. License number		d. Date signed (Month, Day, Year)
			Theodus M. K. A mus	O.C.M.E.		June 1, 2004
			30. Name and address of person who completed cause of death (Item 23a) (Typ		t. Raltim	ore, Maryland 21201
			THEO DONE MIKING 31. Date filed (Month, Day, Year) 32. Registrar's Signature	TIT TOM DELCE	C, DELCHIE	ozo, razi man ereor
	St Regist	ate rar	JUN 0 8 2004 Keen & Soule			

State of Maryland / Department of Health and Mental Hygiene Reg. No Certificate of Death Month 5 2. Date of Death 1. Decedent's Name (First, Middle, Last) 20 2004 9:10 **Physician** aM Michael Wilheart Dozier /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGES CHERRY LANE NURSING CENTER LAUREL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex 5. Social Security Number Days **Funeral** Min. Hours XXM 2□ F Yrs. 1959 WASHINGTON, Director 44 578 80 6792 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State is 23a or 28a-f show XX Yes 2 No LANDOVER PRINCE GEORGES MARYLAND 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number UNITED STATES 20785 6529 WEST FOREST ROAD Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes XX No If Yes, Give Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married XX Married 1 ☐ Yes XXNo Specify: Specify: BLACK ō 21215-0036 If Yes, Give Year or Dates: þ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE LABORER 11TH 18. Mother's Name (First, Middle, Maiden Sumame) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be it of Health and Mental LEE DORA BERRY ဂ SAMUEL DOZIER, JR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BLADENSBURG, MD 20710 6010 LOGAN WAY #B3 BERNICE DOZIER / WIFE or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition XX Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or RESSURECTION CEMETERY 29 MAY 2004 CLINTON, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign, ture of Fyneral Service Licenses 22. Name and Address of Facil MARSHALL'S FUN FUNERAL HOME OF MARYLAND, INC. 4308 SUITLAND ROAD SUITLAND, MD 20746 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a metastertic **Physician** Carunama disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner The law requires that the death certificate be executed that initiated events and resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the 38 IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 2 Fetal death Day Month Yaar for in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.0. the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records. should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? 2 **□** ₩0 of Vital Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3□ DOA ျ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient After this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Medical Certification: Division 5 Pending 1 Matural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide in by 4 | Homicide the Hospital or within 24 hours a To the Funeral Completely filled 29a. Certifier 🗠 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D23/8/ PMI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) . M.D. 704 Gooman Ave # T-1. Laurel, AD 20707 R.G. BHOJRAJ 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

2004

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ORIGINAL

			1 - For State Registrar	State of Man		artment of F			ene 004	20260
	Physici /Medio Examin	al	Decedent's Name (First, Middle, Last) Warren Bird Ducke 4a. Facility Name (If not institution, give s	ett, Jr.		4b. City, Town, o	r Location of De	0000	Day Year 10 2004 4c. County of Dea	
	LXaiiii	le i	Ginger Cove Health				Annapol:		Anne A	
	Funeral Director		5. Social Security Number 6. Sex 220–36–6021	14 000	n yrs. last birthday, 64 Yrs.	Months Days	If Under 24 H Hours Mi		(ear) 9. Bir Co 1939 Ma	thplace (State or Foreign ountry) aryland
	Maryland	tor	10a. State 10b. County Maryland Anne Ar		Oc. City, Town or L	ocation	Annar	∞lis	-	10d. Inside City Limits
	or 288	Funeral Director	10e. Street and Number			10f. Zip Code	24.404	10	g. Citizen of What Co	•
	eath w	erai	208 Wardour Drive	12. Was Decedent Eve	rin U.S. 13	Was Decedent of H	21401	(Specify Yes or No-	U.S.	
9036	ours after d ral', or Iten Examana	b	1 □ Never Married 2X Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 🌠 No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2X No	Specify:	(Specify Yes or No- erto Rican, etc.)	Black, Whi	te, etc.
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show sayi njury or other traumatic event, I'm Medical Exatic and must be notified at once.	Completed	15. Decedent's Edui (Specify only highest grade Elementary/Secondary (0·12)	cation a completed) College (1-4or 5+) 5+	(Give	ident's Usual Occup e kind of work done DO NOT use retired Judge	during most of w	vorking 10	6b. Kind of Business Legal Sy	
Maryland 2	wild be filed Mental Hyg srked othe	To Be C	17. Father's Name (First, Middle, Last) Warren Bird Ducke	ett, Sr.				ame (First, Middle, Ma Knight Lint	aiden Sumame)	
Man	d 2 sho th and th sum traum		19a. Informant's Name/Relationship (Ty) Judith Duckett/wi					Annapolis,		
Baltimore,	Pages 1 an lent of Heal nt: If item 2 ry or other		20a. Method of Disposition 1★★urial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)		20b. Place of Disponentery, cre		ce)	Date 20	Oc. Location · City or	
Balti	permit. Departm Importa eny inju		21. Signatur uneral service License	e Le				ohn M. Tayl ester Annap		1 Home 21401
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, fary, leading to ammediate	ne cause on each line. Due to (or as a co	tiple :	ter the mode of dyin		iac or respiratory arres	t,	Approximate Interval Between Onset and Death
8760,	icate be executed physician and s the burial-transit	dicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co						
P.O. Box 6	death certif e attending id for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3[□Ectopic pregnancy □ Other (specify) _	/		23d. Date of de Month	livery Day Year
	w requires that been signed b should be deta		Part II. Other significant conditions con	ntributing to death but n	ot resulting in the u	underlying cause giv	en in Part I.			o the cause of death?
l Records,	e las has je 2	Completed						24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of
of Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	lo spital:		Oth	00	eath (Check only one)		
on of	ding Phys	tion; To	1 Yes 25 No 27. Manner of Death 1 5 Natural 5 Pending 2 Accident investigation	1 Inpatient 28a. Date of Injury (Month, Day Ye	2 ER/Outpatie 28b. Time o Injury	of 28c. Injur Wor	4 Mursing	Home 5 Residen 28d. Describe how		cify)
Division	To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (reet, factory, office		28f. Location (Stre City or Town,	et and Number or Ri State)	ural Route Number,
	Hospital or 1 24 hours after Funeral Dire stely filled in b	edical (29a. Certifier 1 Certifying Physic (Check only one)	sician: To the best of n ner: On the basis of ex and manner stated	amination and/or in	th occurred at the time	ne, date and pla pinion, death oc	ce, and due to the cau curred at the time, dat	se(s) and manner as e and place, and due	s stated. e to the cause(s)
)	To the within 2 To the comple	Me	29b. Signalure and title of certifier	bh ~ >		29c. Licens	e number		d. Date signed (Mont	
			30. Name and address of person who co			, Print)				
	CA.		Dr. William Dabbs 31. Date filed (Month, Day, Year)	277 Penir		m Road	Arnold,	MD 21012		
	Sta Registi			2004	w B	bole				

	(L	.*	For State Registrar	State of Marylan		artment of H tificate of		nd Mental	Hygien	7004	20261
			1. Decedent's Name (First, Middle, La	st)				2. Date	of Death		3. Time of Death
	Physici		John	Peter		Paniel	son.	II Jur		ay Year 2001	1 03:25AM
	/Medic Examin		4a. Facility Name (If got institution, give			4b. City, Town, o				c. County of Deal	th
	LAGIIII	ICI	The Tobace 4	sokins Hospi	401	130 L+	Trund	00.56	7		
3	Funeral		5. Social Security Number 6.8	ex 7. Age (In yrs.	last birthday)	If Under 1 Year		4 Hrs. 8. Date	of Birth	9. Birt	hplece (State or Foreign
	Director		079-38-9804	IQXM 2□F 48	Yrs.	Months Days	Hours	Min. (Moon	ћ, Day, Yea 19	1	ssouri
В.			Usual Residence of Decedent					31 60.1			
	nylan how		10a. State 10b. County	10c. City	y, Town or Lo	cation					10d. Inside City Limits
	e-fs	cto	Maryland Prince	Georges Bow:	ie						1 X Yes 2 No
	be filed within 72 hours after deeth with the Maryland tial Hygiene. do other than "naturel", or Items 23a or 28e-f show event, the Medical Examine must be notified at	Funeral Director	10e. Street and Number			10f. Zip Code			10g. C	Citizen of What Co	ountry?
	th w	al	13924 Westview Fo	rrest Drive		20720				U.S.A.	
	ems	nei	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of H	Hispanic Orig	in? (Specify Yes Puerto Rican, etc	or No-	14. Race - Ame Black, Whit	
õ	or It	F	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 ☐ No If Yes, Give		1 ☐ Yes 2 ☐ No	Specify:			L 955	White
2-003e	Jurel',	d by	3 Widowed 4 Divorced	Year or Dates:		21					
ก	72 h natu disa	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	(Give	lent's Usual Occup kind of work done	during most	of working	16b.	Kind of Business	Industry
2	within ene.	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire chitect	id)		Co	onstruct	ion
N	e filed v Il Hygie other t vent, th	ပိ	17 Februario Name / First Addition / acc	5+	211		19 Mothor	's Name (First, M			2011
yland	uld be filk Mental Hy irked oth	Be	17. Father's Name (First, Middle, Last John Nesbitt						Louise		on
<u>X</u>	s 1 and 2 should t f Heatth and Ment Item 27 is marked other traumatic d	ပို									
Z	2 sh and ls m		19a. Informant's Name/Relationship		1	ng Address (Street					
<u>~</u>	and leatth m 27	1	Donna Danielson/				w Forr		-		yland 20720
0	of H of H if Ite		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	emetery, <u>c</u> rer	sition (Name of natory or other pla	ce)	Date / 1.0 / 2.00 /		Location - City or	
Ē	Pages ment of ant: If It ury or o	1	* 4 □Donation 5 □ Other (Speci	fy) Hu		ematory	<u> </u>	/19/2004		ldorf, M	
Baltimor	permil. Pages Department of I Important: If Ite eny injury or o'		21. Signature of Fund Service Lice	nsee		. Name and Addre					
ш_	% O E ≥ O		· fall		16	000 Annaj	polis :	Road, Bo	wie, 1	Maryland	20715
			23a. Part F. Enter the disease, or conshock, or heart failure. List only		n. Do not ent	er the mode of dy	ng, such as c	ardiac or respirat	ory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	· anoxic	main	injuvu					Onset and Death
	/Medical		resulting in death)	a. Due to (or as a consequence		Jarry					3 1(000 3
	Examiner		Commentally lies are distant	b							
li in	EYTOE	Je.	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence	uence of):						
	cuted ad ransi	Examine	cause. Enter Underlying Cause Olisease of injury that initiated events	c						1	
'n	be executed ician and burial-transit		resulting in death) Last	Due to (or as a consequence	uence of):						
2/60		Ical		_ d							
õ	certificate iding phys	ed									
X Q Q	leath certific attending p	Z	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna		Ectopic pregnanc	v		-	23d. Date of del	,
_	0 0 0	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of d		Other (specify)	,			Month	Day Year
J.	at the de by the a tached	Physician/Med	9 □Unknown	9□ Unknown							
	law requires that the as been signed by the 2 should be detache	by P	Part II. Other significant conditions	-	ulting in the u	nderlying cause gi	ven in Part I.	23e.	Did tobacco	use contribute to	the cause of death?
cords,	quire n sig uld b	pe	liver failur	e					1 🗌 Yes	2 □ No 3 □ Pr	obably 4 Onknown
ပ္ပ	s bee	Siet							Wasan	24b. Were at	itopsy findings available
Ä	sician: The law certificate has b irector, page 2 s	Completed							autopsy performed?		completion of cause of
Vital	in: T ficet or, pë	Ö	25. Was case referred to medical				26 Place	of Death (Check		lo 1 ☐ Yes	2 No
5	Physician: this certifice ral director, p	0	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Mapatient 2	ER/Outpatier	. 30 DOA Ott				6 □Other (Spe	out ()
Ö	or Attending Physician: Ifter death. Director: After this certific in by the funeral director,		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of		ry at			ury occurred	City)
0	ding P	to	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury		rk?]Yes 2.∐N	lo			
S	Attendii death. ctor: A y the fu	fica	3 ☐ Suicide 6 ☐ Could not I	28e. Place of Injury - At ho	ome, farm, str	eet, factory, office					ıral Route Number,
DIVISION	after Dire	Certification;	4 Homicide	building, etc. (Specif	v)			City	or Town, Sta	ite)	
	Hospitel 4 hours a Funeral C		29a, Certifier 1 Certifying P	hysician: To the best of my kno	wledge, deatl	occurred at the ti	me, date and	place, and due to	the cause	s) and manner as	stated.
	To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medicai	(Check only 2 Medicel Exa	miner: On the basis of examina and manner stated.	tion and/or in	vestigation, in my	opinion, death	occurred at the	time, date a	nd place, and due	to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. D	ate signed (Mont	h, Day, Year)
)	F 5 F 5		Monana M	\		000	-000		1	ne 14,20	V~ 1
			30. Name and address of person who		23a\ /T		- 440		VCCI	14/20	Ч
				·			6	Summer D.	D. I form	~ Marine	and 21287
100	CA	ate	31. Date filed (Month, Day, Year)	OUNS Hookins Ho	ture	NOTH	WOHE	OFFICER DO	IMUNO	E mary le	TOTAL ALLET
	Regist		JUN 16	2004 Marie		hoole					

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

		A	MEND ITEM #20B PER		•					•	Reg. No.) [,	20252
	Physici	an	Decedent's Name (First, Middle, Les Howard William Das							Month	Day	Year	3. Time of Beath
	/Medic		4a Fecility Name (If not institution, give					4b. (City, Town, or L	mA7		of Death	6:30 An
1	Examin	eı	Sunrise Assisted 1					Se	verna F	ark	Anne	Arun	ıdel
	Funeral Director		2,0 11 0011	7. Age	e (In yrs. i	last birthday) Yrs.	If Under 1 \ Months D		Under 24 Hrs. Hours Min.	8. Date of Bir (Month, De Sept.	th 19, Year) 6, 1923	9. Birthp Coun Mar	lace (State or Foreign try) yland
	aw.	-	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	ocation					1	0d. Inside City Limits
	Maryl a-f ehc	tor	MD Anne Art	undel	Se	verna	Park						1 ☐ Yes 2 ☑ No
	death with the Marylend ms 23a or 28a-f ehow r maat be notified at	Funeral Director	10e. Street end Number 108 Giddings Aver	nue			10f. Zip Co	1146			10g. Citizen of V	Vhet Cour SA	ntry?
020	ō ₽ 2	by Fune	11. Marital Status 1 ☐ Never Married 2 ☆ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ⊈Yes 2 ☐ N If Yes, Give Year or Detes:			Was Deceden If Yes, specify 1 ☐ Yes 2【			ecify Yes or No Rican, etc.)	Blac	e - Americ k, White, Whi	
21215-0020	permit. Pages 1 and 2 should be filed within 72 hours aft Department of Health end Mental Hygiene. Important: If item 27 is marked other then "netural", or any Injury or other traumatic event, the Madesil Exercitions.	Completed by	15. Decedent's Edi (Specify only highest gred Elementary/Secondary (0-12)	de completed) College (1-4or 5	+)	(Give life.	dent's Usual O kind of work of DO NOT use r	lone durii etired)	n ing most of work	ing	16b. Kind of Bu		
d 2	filed v Hygie ther t	ပ္	17. Father's Name (First, Middle, Last)	5+				-	. Mother's Nam	e (First, Middle,	Maiden Sumam		
Maryland	ld be ental ked o	To Be	Howard W. Dashie	lls, Sr.					Lillia	n Heacc	ck		
ary	shou and M mari	-	19a. Informant's Name/Relationship (T	ype, Print)		19b. Maili	ing Address (S	treet and	Number or Rui	el Route Numb	er, City or Town,	State, Zip	Code)
	and 2 patth e 27 is		Elizabeth Dashie	lls/Wife							a Park,		
Baltimore,	Pages 1.ment of He ant: If item ury or oth		20a. Method of Disposition 1 XBurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify,		MD 20b. P	lace of Dispo emetery, cre Veter	osition (Name matory or othe cans Cer	of r place) nete:	ry	Date 28 May 21, 2004	20c. Location -		
Balt	permit. Depart Import any Inl		21. Signature of uneral Service Licens	or and the same					ons, P.		erna Pai erna Pai		neral Home D 21146
			23a. P. 11. Enter the disease, or comp mock, or heart failure. List only of	lications that caused one cause on each lin	the death	. Do not en	ter the mode o	f dying, s	uch as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical Examiner	_	Immediate Cause (Final disease or condition resulting in death)	END		GE r as e conse		ENT	14				Oriset and Death
60,	tificate be executed ig physician end es the buriel-trensit	ai Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b	Due to (or	r es a consec	quence of):						
Box 68760,	E 00	n/Medicai	resulting in death) Last	d	Oue to (or	as e consec	quence of):						
	deatl	Physician/	Part II. Other significent conditions co	ntributing to death bu	it not resu	ulting in the u	inderlying caus	e given i	n Part I.	23b. Dld	tobecco use cor	ntribute to	the ceuse of death?
s, P.O	requires thet the death cert een signed by the ettendin nould be deteched for use	by Phy								10	Yee 2□ No	3 🗆 Prob	eably 4 Unknown
Records,	aw requir	Completed t								24a. Was perfo	an autopsy rmed?	ava	ore autopsy findings ailable prior to npletion of cause death?
<u>=</u>	F age	5								10	(SE 2134NO	10	Yes 3LINe
of Vital	Physiclan: The this certificate and director, page	B	25. Was case referred to medical examiner?	Hospital:				Other		h (Check only o		A5515	
	ng Phys ter this ineral di	tion: To	1 ☐ Yes 2 1 ☐ Wo 27. Manner of Death 1 1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigation	1 ☐ Inpatient 1		ER/Outpatie 28b. Time o Injury	nt 3□ DOA of 28c. M	Injury et Work?		ome 5 🗆 Resid 28d. Describe I	dence 6 Other		,)
Division	To the Hospital or Attending within 24 hours effer deeth. To the Funeral Director: Attencompletely filled in by the fune	edical Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc	ıry - At ho :. (Specify	me, farm, st	reet, fectory, of	fice		28f. Location (: City or To	Street and Numb vn, State)	er or Rura	l Route Number,
	Hospita 24 hours Funeral etely fille	dical C		sician. To the best of iner: On the basis of and manner sta	examinat								
	ro the vithin Fo the	Me	29b. Signature and title of certifier				29c. Li	cense nu	ımber		29d. Date signed	(Month, I	Day, Year)
			nama	MD			I	57	531		May 2	5 2	004
			30. Name and address of persor who o	ompleted ceuse of de	eth (Item	23e) (Type,	Print)						
			Mohir Negi B	601 Vet	eras	ns H	wy 1	M,L	lersvi	ue, 1	no 21	108	
	Sta Registr		31. Date filed (Month, Day Year)	60) VCT 2004 32. Registra	r's Signal	ture	bod						

Amended Item #26 per physician 06/15/04 cs

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

' 15	/04 cs	1	For State Registrer	State of	of Marylan	-	rtment of Hetificate of D		Mental Hygi ™	ene g. NB. N N	1. 5	20262
	Physicia		1. Decedent's Name (First, Middle Genevieve C. D						2. Date of Death Month May 29	Day	Year	3. Time of Beam 10:13 A.M
	/Medic Examin		4a. Fecility Name (If not institution 11 Primo Vista	n, give street and ne	umber)		4b. City, Town, or McHenry	Location of Deat		4c. County of		100110
	Funeral Director		5. Social Security Number OO4-16-7120	6. Sex 1 ☐ M 2 🖺 F	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		⁴ 1921	9. Birthpla Countr Main	
Ī	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show the Maudreal Examinat must be notified at	Olrector .	Usuel Residence of Decedent 10a. State 10b. County Maine Frank 10e. Street and Number			. Town or Lo			10	g. Citizen of W		d. Inside City Limits 1X Yes 2 □ No
	be filed within 72 hours after death with the Marylan Ital Hygiene. od other than "naturel", or flems 23a or 28a-1 show event, the Madical Extending out be notified at	Funeral Dir	213 Titcomb Hi		cedent Ever in U.	S. 13.	04932 Was Decedent of His f Yes, specify Cubar	spanic Origin? (S		US/		ın Indian,
9000	hours after ural', or fte	۵	1 Never Married 2 Mar 3 Widowed 4 Divorced	ned 1 □Yes If Yes, G Year or	2 🔼 No live		1 ☐ Yes 2 No	Specify:		Specify:	whi	ite
Maryland 21215-0036	filed within 72 Hygiene. Ither then "net ent, the Madic	Completed	(Specify only higher Elementary/Secondary (0-12)	nt's Education est grade completed College 5 yr	(1-4or 5+)	(Give	kind of work done d DO NDT use retired)	uring most of wo	rking	Public		
land 2	2 should be filed and Mental Hygie is marked other raumatic event, I	To Be C	17. Father's Name (First, Middle, Edward Clark	Last)				Luella	me (First, Middle, M Richards			
	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic: 0008.		19a. Informant's Name/Relation Darlyne A. McI 20a. Method of Disposition			8014			ithersburg	•	20882	2
Baltimore,	it. Pages I itment of H itant: if ite njury or ot	i	1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (3	Specify)		emetery, crei itry Si	de Cremat	ory Jun	e 1,2004	Davids	sville	
Ba	permit. Departr Imports any inju		23a. Part1. Enter the disease, c shock, or heart failure. Lis	Heun	caused the deat	17	9 Miller	St., Gra	es, P.A., antsville c or respiratory arre	, MD 2	1536	Approximate Interval Between
	Priysician /Medical Examiner		Immediete Cause (Final disease or condition resulting in death)	_ a /	o (or as a conseq	Holdy	dis 1 I	Infanct	wh			Onset and Death
8760,	cate be executed by sician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	6	o (or as a conseq							
P.O. Box 68	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the buriat-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 M No 9 ☐ Unknown	1□Live	outcome of pregna birth 2 Fete gnant at time of d known	Ideath 3	Ectopic pregnancy Other (specify)			23d. Date Mon	of deliver	ry Day Year
	w requires that t s been signed by should be deta	Ď	Part II. Other significant condit	ions contributing to	death but not res	ulting in the u	nderlying cause give	on in Part I.			ibute to the	e cause of death?
Reco	Physician: The law re this certilicate has bee ral director, page 2 sho	Completed							24a. Was ar autopsy perform 1 Yes 2	ed? d	rior to com eath?	sy findings available apletion of cause of
/ita	Physician: rthis certificated and director, I	Be	25. Was case referred to medic examiner?	Hospital:			othe Othe		ath (Check only one			Daughter's
Division of Vital Records,	ading Phys th. : After this e	atlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pend 2 Accident inves	28a. Dat	□ Inpatient 2 □ le of Injury onth, Day Year)	28b. Time of Injury	f 28c. Injury	4 Nursing	28d. Describe ho			Summer Home
Divis	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical Certification:	4 Homicide	mined 286. Pla bui	Iding, etc. (Specia	ý) 	reet, factory, office		28f. Location (Str City or Town	, State)		
	the Hospi nin 24 hou the Funer npletely fill	Aedical	(Check only 2 Medice one)	I Examiner: On the and ma	he best of my kno basis of examina anner stated.	owledge, deal ation and/or in	h occurred at the tim vestigation, in my or 29c. License	oinion, death occ	e, and due to the ca urred at the time, da	use(s) and mar te and place, a	ind due to	the cause(s)
	100 CO CO CO CO CO CO CO CO CO CO CO CO CO	4	29b. Signature and title of certif	ugh my)	n 22a) /Tu	D3	3464		May 30		
	4		30. Name and address of person Robert M. Cou					n, WV 2	6716			
	St Regist	ate rar	31. Date filed (Month, Day, Yea	1 2004	Registrar's Sign	ature	Constant.					

or than "naturel", or Itame 23a or 28e-1 show the Medical Exame or must be notified at is marked other

ettending physicien and I for use as the burial-transit The law requires that the deeth certificate be executed Box 68760 signed by the c Records, P.O. Division of Vital

For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 0640 June Arthur Paul Eaton, Jr. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Memorial Easton
If Under 1 Year If Under 24 Hrs. 1 aybot The Hospita Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1**⅓**M 2□ F Months Hours Min. Yrs. 219-56-8937 52 June 23, 1951 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2X No Completed by Funeral Director Maryland Caroline Ridgely 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 24235 Holsinger Lane <u> 21660</u> United States
o- 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Caucasian 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 HS Grad Farmer Farming 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Depertment of Heelth end Mantal Hy Importent: If Item 27 is marked oth any injury or other traumatic event <u>once</u>. Be Arthur Paul Eaton, Sr. Florence Ann Porter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia A. Eaton Sister PO Box 22, Ridgely, Maryland 21660 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Greenmount Cemetery 6/21/2004 ^¹ 4 □ Donation 5 □ Other (Specify) Hillsboro, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Lices Moore Funeral Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Immediate Cause (Final) Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardial Infaction **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant. 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Gastric alcer 1 Yes 2 No 3 Probably 4 TUnknown Diabetes Mellitus uncontrolled 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 100 1 ☐ Yes 2 ☐ No or Attending Physicien: To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funaral Director: After this certific completely filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes 1 Impatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Natural 5 Pendina М 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and tyle of certifier 29d. Date signed (Month, Day, Year) MD 059135 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 215 Bloomingdale Avenue, Federalsburg, MD 21632 Adetunji Adesanoye, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 18

Registrar

Brasti

2004

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deat **Physician** 2004 June 6, M 9:00 a Bernice Louise Ehrler /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 5710 84th Avenue New Carrollton Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Ye. April 5, 1 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🖔 F 83 Director 579-12-5091 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 □ No Directo Maryland Prince George's New Carrollton 10e. Street and Number 10g. Citizen of What Country? 5710 84th Avenue 20784 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ White 3 X Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within. Department of Health and Mental Hygiene. Important: if item 27 is marked other than 7 any injury or other traumatic event, the Mad once. Washington Suburban Elementary/Secondary (0-12) College (1-4or 5+) Account Receivables 12 Sanitary Commission 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Miles Beatrice Rose Hughes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James M. Ehrler - Son 12525 Mill Creek Lane, Wye Mills, Maryland 21679 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 6/10/2004 Brentwood, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signature of Funeral Service Licenses Con as 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Pan1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** en YRS /Medical resulting in death) Due to (or as a consequence of) Examiner Securations list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 as ed by the attending detached for use as IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🕅 No Day Year 5 Other (specify) P.O. 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ as been sign 1 Yes 2 No 3 Probably 4 Onknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Sec certificate ha autopsy performed? 1 Yes 2 No or Attending Physician: funeral director 25. Was case referred to medical 26. Place of Death Check onl. one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending death. investigation М 1 ☐ Yes 2 ☐ No 2 Accident after death Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours a To the Funeral C completely filled i Hospitel 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only 29b. Signature a d title of centile 29c. License number 29d. Date signed (Month, Day, Year) D>2261 MO June 7, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

Richard J. Feldman,

JUN 1 1 2004

31. Date filed (Month, Day, Year)

M.D.

2. Registrar's Signature

9500 Annapolis Road, A4, Lanham, MD 20706

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	1000		For State Registrar			Cei	rtificate of	Death		Reg. No.	104	20266
	Physicia	212	Decedent's Name (First, Middle, I	.ast)					2. Date of Do Month	eath Day	Year	3. Time of Death
	/Medic		Leola	н.			Evans		June	4	2004	7:30 a ^M
	Examin		4a. Facility Name (If not institution, g	ive street and num	iber)		4b. City, Town, o	or Location of Dea	ith	4c. C	ounty of Death	
			7505 Hawthorne S				Landov			P	rince (
	Funeral			Sex 1 □ M 2 🛂 F	7. Age <i>(In yr</i> s. <i>I</i> 8		If Under 1 Year Months Days	If Under 24 Hr Hours Mir	. (Month, D		9. Birth	place (State or Foreign htry)
	Director		217-20-9344 Usual Residence of Decedent			J 1.5.			Dec. 2	20, 19	20 Nort	h Carolina
	land		10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
	Marylan f show	ğ	Maryland Prince	Georges	Lan	dover						1 Yes 2 No
	the 28a	Je C	10e. Street and Number				10f. Zip Code		-	10g. Citize	n of What Cou	ntry?
	death with the Maryland ms 23s or 28s-f show Finant be notified at	Funeral Director	7505 Hawthorne S	treet			20785			U.S.	Α.	
	death	Jere	11. Marital Status		dent Ever in U.	S. 13.	Was Decedent of H	Hispanic Origin? (Specify Yes or N	0- 14	. Race - Ameri	
9	after or Ite	豆	1 ☐ Never Married 2 ☐ Married	Armed For 1 ☐ Yes If Yes, Give	2 ₩ No		1 ☐ Yes 2 ☐ No		nto rican, etc./		Black, White, pecify: Bla	
8	72 hours after natural', or Ite	1 by	3 ☐ Widowed 4 ☐ Divorced	Year or Da	ites:		10165 20140	Броспу.			pecny.	
5-0	72 h 'natu	Completed	15. Decedent's (Specify only highest of	Education grade completed)		(Give	dent's Usual Occup kind of work done	during most of w	orking	16b. Kind	of Business/In	dustry
2	within ene. than "	ld ll	Elementary/Secondary (0-12)	College (1-	-4or 5+)		DO NOT use retire	a)			_	
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anc	htal he find he do ot	Be	Bud Hammie	31/				Meta H		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	annamo,	
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Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryla if Heath and Mental Hygiene. It am 27 is marked other than "natural", or items 23a or 28a-1 show othar traumatic avent, If a Medical Exertination at	1	Charlie Evans/Hu			1	Hawthor					
	1 an Heal am 2		20a. Method of Disposition	Spand	20b. P	lace of Dispo	sition (Name of		Date		tion - City or To	
ᅙ	ages nt of t: If it		1 Burial 2 Cremation 3 4 Donation 5 Other (Spe	☐Removal from S	state		oln Ceme		~ 8 20C	/. D.	on traced	, Maryland
Baltimore,	permit. Pages 1 and 2: Department of Health at Important: If itam 27 Is any injury or other trau	1	21. Signat 7 S. Funural Service Lid		101		2. Name and Addre		e 0, 200	4 DI	entwood	, Maryland
Ba	permit. Departm Importa any inju		May 5	hun	o _i	52	of Biage	ln Funer	al Home	twood	Marv1	and 20722
			23a. Part1. Effer the disease, or co shock, or heart failure. List or	emplications that ca	aused the death						, mary r	Approximate
			shock, or heart failure. List or Immediate Cause (Final									Interval Between Onset and Death
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4	Examiner				odyspla:							
		e.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D. —	or as a consequ							
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oʻ	te be executed ysician and ne burial-transit	Exa	resulting in death) Last	Due to (or as a consequ	ence of):						
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89	The law requires that the death certificate I tte has been signed by the attending physi vage 2 should be detached for use as the b	Med	TE ESTANCE									
Box	th cer endir r use	an/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo	come of pregna		Ectopic pregnanc	y		23	d. Date of deliv	ery Day Year
_	deal death	slci	in the past 12 months? 1 ☐ Yes 2X No		ant at time of de		Other (specify)				MOTRI	Day 18a1
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	es that igned b	þ	Part II. Other significant condition	_	ath but not rest	alting in the u	nderlying cause giv	ven in Part I.				he cause of death?
ord	w requir been si should	ted	Diabetes Melli	tus						70S 2	No 3 ☐ Proi	Dably 42 Olikhown
ပို	e law r has be je 2 sh	ple	Hypertension						24a. Was	psv	prior to co	psy findings available mpletion of cause of
E		Completed by Physician/Medi	Cardiopulmonar	y Disease	2				perī 1 ☐ Yes	ormed? 2 ∑XNo	death? 1 ☐ Yes	2 🗆 No
/ita	ı cian : Th certificate rector, pag	Be	25. Was case referred to medical examiner?				100		eath (Check only	one)		190101-11-07
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ū	ding P h. After t funera	i.	27. Manner of Death 1 XNatural 5 ☐ Pending		of Injury h, Day Year)	28b. Time of Injury	Wo		, 28d. Describe	now injury	occurred	
Sic	Attanding Physician: r death. actor: After this certific by the funeral director,	cat	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	t be Osa Diago	of lainer. At he	mo farm at	M 1 ==]Yes 2 ☐ No	28f Location	(Street and I	Number or Bur	al Route Number,
Division of Vital Records,	or Al	Certification	4 Homicide determin	ed 286. Place buildir	ng, etc. (Specif)	/)	eet, ractory, office			wn, State)	vamber of flate	arriode ramoer,
	To the Hospital or Attandi within 24 hours after death. To tha Funaral Diractor: A completely filled in by the fu		29a. Certifier 1 To Certifying	Physician: To the	best of my kno	wiedne dest	h occurred at the ti	me, date and place	ce, and due to the	Causa(s) a	nd manner as s	tated.
	Hos 24 hc Fun etely	Medical		caminer: On the ba	asis of examinat							
	To the within 2 To tha comple	Me	29b. Signature and title of certifier		1		29c. Licens	se number		29d. Date :	signed (Month,	Day, Year)
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	2)	0	30. Name and address of person w	no completed caus	e of death (Item	1 23a) (Type,	Print)			-1		,
′ ′	رك		14999 Health C					Kel	ly Tauen	holz,	M.D.	
	Sta	ate	31. Date filed (Month, Day, Year)	₽. R	egistrar's Signa	ture		-	-			
	Regist	rar	JUN 1 0 20	U4 /	an A	Apre	We see					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Month Vesi 6:45 ам DOROTHY **EDWARDS** /Medical June 2004 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7531 Greenleaf Road Prince George's Landover If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1941 9. Birthplace (State or Foreign Days 1 □ M 2 131 F 577-58-0841 Director Yrs. 62 Washington, DC Usuat Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. tnside City Limits itam 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be inclified at Director MD Prince George's 1X Yes 2 No Landover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7531 Greenleaf Road 20785 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Yes, Give ear or Dates: Completed by 1 ☐ Yes 2 ☑ No Specify Specify: Black 3 ₩idowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry s 1 and 2 should be filed within if Health and Mental Hygiene. Etementary/Secondary (0-12) Coltege (1-4or 5+) 12th Day Care Provider Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Earl Lee Lenora E. Bands 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 7531 Greenleaf Rd., Landover, MD Karin Edwards/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Filmportant: If ita 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery 06/10/2004 Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) permit. 22. Name and Address of Facility J.B. Jenkins Funeral Home 21. Signature of Funeral Service Licensee 7474 Landover Rd., Landover, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Justian /Medical resulting in death) Due to (or as a consequence ot): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or intury Examiner to (or as a consequence ot): death certificate be executed use as the burial-transit that initiated events resulting in death) Last the attending physician and Physician/Medical IF FEMALE: 23c. It yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown The law requires that the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be Completed 1 Yes 2 No 3 Probably 4 Unknown peed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performed; this certificate Vertur 1 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be S. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: ပို 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 27 Manner of Death 28b. Time of Injury 28d. Describ ow injury occurred Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: After 1 Accident 5 Pending investigation 1 Yes 2 No death within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide in by t 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of Injury - At home, farm, street, tactory, office building, etc. (Specify) determined 4 T Homicide **Carritying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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DHMH 17 Rev 1/2001

State

Registrar

Venkahwaman.P.

JUN 0 9 2004

31. Date filed (Month, Day, Year)

Maryland 21215-0036

Baltimore,

Division of Vital Records, P.O. Box 68760,

inpleted cause of death (tem 23a) (Type, Print)

Romdav6001 Landover Road

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** June 3, a^{M} Raymond Eggleston 2004 5:20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George Pineview Nursing HOme Clinton If Under 1 Year | If Under 24 Hrs. 6. Sex 1 XM 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Director 125-26-6186 70 July 29, 1933 New York Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or items 23a or 28a-f ahov the Medical Examiner must be notified at 1 X Yes 2 ☐ No by Funeral Director Clinton Prince George 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9503 Dalmatia Drive 20735 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Police Officer <u>Metropolitan Police Dept</u> treumatic event. Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be is marked of 1 and 2 should be Edmonia Mickens Taft Eggleston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ant: If item 27 is 9503 Dalmatia Drive, Clinton, MD 20735 Evon Eggleston/Wife other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. ö 4 ☐ Donation 5 ☐ Other (Specify) Md Veterans Cemetery 6/10/04 Cheltenham, MD 21. Signature of Funeral Service Licer 22. Name and Address of Facility Strickland Funeral Services 6500 Allentown Rd, Camp Springs, MD 20748 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran resulting in death) Last Due to (or as a consequence of) Box 68760, attending physician Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) P.0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, pe 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June 4,2004 **Physician** 11:40 PM MILDRED ESCHINGER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bradford Oaks Nursing & Rehab Ctr. Clinton Prince George's 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 ☐ F 89 21,1914 Maryland Director 578-90-8321 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ed other than "natural", or Itams 23a or 28e-f show event, it e Medical Examinar must be notified at 1 XYes 2 No Director MD Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8701 Duvall Road 20772 USA death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 Specify: White Àq Yes. Give 1 Yes 2 No Specify: 3 Widowed 4 Divorced ear or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. snt: If Item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) n/a 9 Housewife 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frank Hrbek, Sr. Frances Bednarik other treumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth F. Eschinger/Son 8701 Duvall Road Upper Marlboro, MD 20772 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Department of the Important: If its any injury or of once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 06/09/2004 | Suitland, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cedar Hill Funeral Home, Inc. permit. 21. Signature of Funeral Service Licenses 4111 Pennsylvania Ave. Suitland, MD 20746 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) SCVD /Medical Due to (or as a consequence of): Examiner CAD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) P.O. I detached the 9 Unknown The law requires that the 9 Unknown signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 反Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performe 2 No 1 Yes 2 X No 1 🗌 Yes or Attending Physician: funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending Injury within 24 hours after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 162 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely, (Check only To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) led 6/8/04 00058797 30. Name and address of person who complet cause of death (Item 23a) (Type, Print) Subashri Reddy, M.D. 11701 Livingston Road Ft. Washington, MD 20744 Date filed (Month, Day, Year) 32. Registrar's Signature State 2004 8 0 NUL

DHMH 17 Rev 1/2001

Registrar

		•	for State Registrar	State of M	arylan	•			lealth a Death			jiene eg. No.2 (nnı.	20	071
the	Physici	an	1. Decedent's Name (First, Middle, La Alfred Filer F	- /		<u> </u>					2. Date of Dea May 30	th	Year	3: Time 3:15	of Death D M
	/Medic Examin		4a. Facility Name (If not institution, give National Lutheran	e street and number;)			Town, or	Location o			4c. Cou	nty of Death	1	Р м
	Funeral Director		5. Social Security Number 577-32-0061	Sex 7. Ag	ge (In yrs. 78	last birthday) Yrs.	If Unde Months	Days	If Under: Hours	24 Hrs. Min.	8. Date of Birth (Month, Day May 4,	, Year)	Col	nplace (Stat intry) hingt	e or Foreign
	land		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation								City Limits
	a Mary	tor	Maryland Montgo	omery	F	Rockvil	l1e								es 2 🗆 No
	th with the 23a or 28 Ist be not	al Director	10e. Street and Number 9701 Veirs Drive				10f. Z	208.	50		1	0g. Citizen (of What Co	untry?	
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-1 show aumatic event, Ite Mcdical Examinar must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces' 1 ⊋ Yes 2 ☐ If Yes, Give Year or Dates:	? No		Was Dece If Yes, spe 1 ☐ Yes	cify Cuba	ispanic Orion, Mexican Specify:	i, Puerto F	cify Yes or No- Rican, etc.)	E	Race - Amei Black, White cify: Wh	, etc.	,
1215-0	within 72 ho ane. Ihan "natur ie Modical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		5+)	life.	kind of w DO NOT I	ork done d use retired	durina most		ng	16b. Kind of	Business/I	ndustry	
Maryland 21215-0036	uld be filed v fental Hygie rked other t tic event, iii	To Be Co	17. Father's Name (First, Middle, Last, Alfred Filer Fl		-	COLL	70146	LA	18. Mothe	r's Name	(First, Middle, Riddle				
Mary	permit. Pages 1 and 2 should be Department of Health and Menia Important: If item 27 Is marked any injury or other traumatic a <u>once</u> .		19a. Informant's Name/Relationship (Patrick A Flynn	,, ,							Route Number Berlin			ip Code)	
altimore,	ges 1 at of the lift item or other		20a. Method of Disposition 1 ☐Burial 2 ☐Cremation 3 ☐	Removal from State		Place of Dispo emetery, crer	sition (Na natory or	me of other plac	θ)			20c. Locatio	n - City or 1	own, State	,
i ii	nit. Pa artmer ortent: injury e.		4 □ Donation 5 □ Other (Specifical Signature of Funeral Service Licer	· · · · · · · · · · · · · · · · · · ·	Fo	ort Lin	Name a	nd Addres	s of Facility	v	3/2004		twood		
ñ	Ded Per Sun Sun Sun Sun Sun Sun Sun Sun Sun Sun		> Myslin T	. Klobei	<i>t</i>	3	3401	Blad	ensbu	rg R	ort Li	ewood Ewood	FB ⁿ 28	722 ^{Ho}	me
	Physician // Medical Examiner and prize pr	dical Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	ine. wm O s a conseq S + w	uence of):			R c					Approxim Interval E Onset an Jwee Jye	etween
Box 6	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerat Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Feta	Ideath 3	∃Ectopic p ∃Other (s	oregnancy pecify)				1	Date of delin	rery Day	Year
rds, P	quires that n signed b ıld be deta	þ	Part II. Dther significant conditions of				nderlying	cause give	en in Part J.			oacco use co		the cause o	
Reco	The law require ate has been sin page 2 should be	Completed	atrial tib	ructive p						_	24a. Was a autops perform	v	b. Were aut prior to co death? 1 ☐ Yes	ompletion of	s available cause of
Vita	icien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe	20		(Check only on	Θ)			
ō	g Phys ter this neral di	n: To	1 Yes 2 WNo 27. Manner of Death	1 ☐ Inpati 28a. Date of Inji (Month, Da	ury	28b. Time of		OA 28c. Injury Work	at 412Nu		ne 5 Reside 8d. Describe ho			ify)	
Division of Vital Records, P.O.	To the Hospital or Attending Physicien: The la within 24 hours after death. To the Funerat Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	n GRo Diago of In	jury - At ho	Injury ome, farm, str y)	M reet, facto	1 🗆 '	Yes 2 □ Î		8f. Location (St City or Town	reet and Nu	m <i>b</i> er or Rui	al Route Nu	ımber,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical Ce	29a. Certifier (Check only one) 1 Certifying Pr	nysicien: To the best niner: On the basis of and manner s	of examina	wledge, death	h occurred vestigation	at the tim	ne, date and pinion, deat	d place, a th occurre	nd due to the ca	ause(s) and ate and plac	manner as e, and due	stated.	o(s)
1	To the To the To the Comp	M	29b. Signature and title of certifier	200 11				c. License				9d. Date sig			
0	(1)		30. Name and address of person who	completed asses -	-M	10 232) (T	- 4)50	06/1			May	31,2	100 7	
	(1)		Samuel Maller M			s Driv		ockvi	lle M	1D 20	850				
	Sta Registr		31. Date filed (Month, Day, Year) JUN 0 9 2004	32. Regist	4.0	ature	2								

		Please Type or Pri			k. Ensure A		_	jible.
		1 - State Registrar	•	Certificate o		•	Reg. No.	04 20272
Physic	an	1. Decedent's Name (First, Middle, Last) Charles E. Fletcher				2. Date of De Month	Day	3. Time of Death
/Medi Examir	cal	4a. Facility Name (If not institution, give street and number, Doctor's Community Hospital		4b. City, Town	n, or Location of Deat	h May	30, 20 Coun	co'4 2:34A M
		Ĭ	e (In vrs. last birth	(day) If Under 1 Ye			th	Birthplace (State or Foreign
Funeral Director			ge (In yrs. last birth 59 Yı	rs. Months Day	ys Hours Min.	April 15	, 1945	Mary Land
yland		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location	T .1.			10d. Inside City Limits
he Mar 8a-f sl	Director	Maryland Anne Arundel		1.21 - 1.2	Lothian			1 XYes 2 □ No
with th		10e. Street and Number 929 Ben Jones Lane		10f. Zip Cod	° 20711		U.S	f What Country?
death Ims 2:	Funerai	11. Marital Status 12. Was Decedent Armed Forces		13. Was Decedent of	of Hispanic Origin? (Suban, Mexican, Puer	Specify Yes or No		ace - American Indian,
idfyidfild Z [Z 3-0050 2 should be filed within 72 hours after death with the Maryland and Mantal Hygiene. Is marked other then "netural", or itams 23a or 28a-f show eumatic event, the Wedfoll Evarians rountite routified at	by	1 Yes 2 If Yes, Give Year or Dates:		1 ☐ Yes 2/QX/		to ritean, etc.))	lack, White, etc. hify:BLack
n 72 hc	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. C	Decedent's Usual Oc Give kind of work do	cupation ne during most of wo tired)	rking	16b. Kind of	Business/Industry
yiene.	omp	Elementary/Secondary (0·12) College (1·4or	5+)	Maintenance	_		Bowie S	tate College
	BeC	17. Father's Name (First, Middle, Last)	-			me (First, Middle		ıme)
arylary should ba nd Mantal marked o	P	William Fletcher	105	Addition Address (Chr	eet and Number or Ri	Mary Ida J		- Charles 72 - Control
Man nd 2 sh lith and 27 is n		19a. Informant's Name/Relationship (Type, Print) Memie Sellman (Sister)			Lane Lothian			n, State, ZIP Code)
DEALLIMORE, INITIVIST PLATE PERMIT PAGES 1 and 2 should by Department of Health and Manta Important: If item 27 is marked eny injury or other treumatic en QDE&.		20a. Method of Disposition 1 ☑ Burial ➢ ☐ Cremation 3 ☐ Removal from State	20b. Place of I	Disposition (Name of crematory or other)	place) I I	Date 9, 2004		n - City or Town, State nian, Maryland
Dallimor Permit. Pages Department of I mportent: If it any injury or o		`4 □Donayon 5 □Other (Specify) 21. Signal, e of Funeral Service Licensee	PDSes C	•	dress of Facility R	_		
Dan permi Depa Impo		21. Signal re of Funeral Service Licensee	حــر		PLACE, N.E. V			20019
8		23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each Immediate Cause (Final	d the death. Do no	ot enter the mode of o	dying, such as cardia	c or respiratory a	rrest.	Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death) Due to (or as	a consequence of	ns Ly	Mphomo	2		2 Weeks
Examiner		Sequentially list conditions, b. Due to conditions	cute 1	Kenal	failure	2		2 Weeks.
utad i insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	to Ro	shirator	ru Lais	lure		2 weeks
ou, e executad ian and urial-transit	Exa	that initiated events resulting in death) Last C. Due to (or as	a consequence of		7			
oo/o	dical	d						
. BOX DO/ON death certificate be e attending physicia d for use as the bur	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome		0.00			, 23d. D	Pate of delivery
	sicia	in the past 12 months?	2 Fetal death it time of death	3 □Ectopic pregna 5 □ Other (specify,			М	fonth Day Year
dS, F.C. I		Part II. Other significant conditions contributing to death	out not resulting in t	the underlying cause	given in Part I.	23e. Did t	obacco use cor	ntribute to the cause of death?
as been signed by the 2 should be detache	ed by					10	Yes 2 □ No	3 Probably 4 NUnknown
ecords law requires as been sign	Completed					24a. Was	an 24b.	. Were autopsy findings available prior to completion of cause of
VICAL MEC sician: The law certificate has b irector, page 2 s						perfo 1 ☐ Yes	ormed? 2 No	death? 1 ☐ Yes 2 XNo
	o Be	25. Was case referred to medical examiner? 1 Yes	ent 2 ER/Outp	patient 3 DOA	Othor	ath <i>(Check only c</i> dome 5 ☐ Resid		ther (Specify)
	I	27. Manger of Death 1 Death 28a. Date of Inj (Month, Date of Inj (Month, Date of Inj			njury at Nork?		how injury occu	
Signal Si	catic	2 Accident investigation		M 1	☐Yes 2☐No	006 1 1: (
F Sire	Certification	determined 208. Flace UI II	tc. (Specify)	m, street, factory, offic	Ce	City or Tou		nber or Rural Route Number,
چ ڌ ۽ ة	Medicai (29a. Certifier (Check only one) 1 Certifying Physician: To the bess 2 Medicel Exeminer: On the basis and manner s	of examination and/	death occurred at the or investigation, in m	e time, date and place by opinion, death occu	e, and due to the urred at the time,	cause(s) and m date and place	nanner as stated. , and due to the cause(s)
To the H within 24 To the F complete	Me	29b. Signature and title of certifier			ense number			ed (Month, Day, Year)
		30. Name and address of person who completed cause of			33482			Poth, 2004
(6)		Sajeev Anand M.D. 734	-3-A Ha:	nover pa	arkway,	Greenb	elt, M	aryland 20854
St Regist	ate	31. Date filed (Month, Day, Year) 32. Regist	rar's Signature		, ,			
DHMH 17 Rev 1/2		JOH U J COOT PLANE.	- 10					

DHMH 17 Rev 1/2001

			For State Registrar	State of Marylan		rtment of H tificate of D			jiene •9. №2 Ո Ո	11.	20272
	3		Decedent's Name (First, Middle, Last)					2. Date of Dea	th		3. Time of Death
	Physici		Richard E	Foster				Month	L. Day	reer	1574 M
	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of Deat	h	4c. County of	Death	
	LAGITIE		Prince George	is Hospit	in	Che	verle		Prince	e 6-	eoges
- 37	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		Yearl	9. Birthplac	ce (State or Foreign
	Director		220–16–7718	M 2□F 7	7Yrs.	Months Days	Hours Mill.	October 4	1926	Maryla	
	D.		Usual Residence of Decedent	40- Cib	. Tau 1					104	f. Inside City Limits
	show	-	Maryland Prince Geo		, Town or Lo		lar Height	c		100	1 Yes 2 No
	Ba-f	Director		ige 3			or respic		10- Civi4 14/6	-1.61-	
	with ti	ā	10e. Street and Number			10f. Zip Code	007/0		log. Citizen of Wh	_	<i>,</i> t
	s 234	ara	6213 L Street	12. Was Decedent Ever in U.	S 13 V	Vas Decedent of Hi	20743	Specify Ves or No-	U.S.A	- American	Indian
	Itam Itam	nu.	11. Marital Status 1 Never Married 2 Married	Armed Forces? 1 XYes 2 ☐ No	3.	Yes, specify Cuba	n, Mexican, Puer	to Rican, etc.)		White, etc	
38	urs at	by Funeral	3€Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1	I□Yes 2☐XNo	Specify:		Specify:	Black	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or Itams 23a or 28e-f show yit, the Medical Exaciliner must be indiffed at	ted	15. Decedent's Educ	cation	16a. Deced	lent's Usual Occupa	ation	dia	16b. Kind of Busi		
215	nin 7.	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done of OO NOT use retired,		irking	Departmen		
21;	filed with Hygiene. kher thai	Completed	Elomonial y document y (o 12)	1	T	ruck Driver	•		(Re	etired)
	al Hy rothe	Be	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,	Maiden Sumame))	
<u> a</u>	should be nd Mental marked c	To E	George Fos	ter				Mable M	aidin		
Maryland	2 sho and l	3 1	19a. Informant's Name/Relationship (Type			g Address (Street a					
	1 and 1 Health tem 27		Kimberly R. Wimbush (D			Littleton S	street Sil				
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or Itams 23a or 28a-f show any injury or other traumatic event, the Medical Exacting Italian and Ance.		20a. Method of Disposition 1 ABurial 2 Cremation 3 R	emoval from State	lace of Dispo	sition (Name of natory or other place Orial Park	e) Irm		20c. Location - C		
Ĕ	permit. Pages Department of H Important: If Its eny injury or of		`4 □Donation 5 □ Other (Specify)	IAII					Landover,		31.171
at	Depart Import eny inj		21. Signature of Funeral Service License	90 / /		. Name and Addres					
ш_	70 E 2 9		penel C.	malest	43	39 HINT PLA	Œ, N.E.	WASHINGTON,	D.C. 200		
μ			23a. Pagi. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the death ie cause on each line.	n. Do not ente	er the mode of dying	g, such as cardia	c or respiratory arr	est,	l In	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	Atherosol +	ritiz	CATCHEV	Asculor	Heart.	Dis eas	20	miset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ							
и	Examiner	_	Eaquentially list sunditions, h	L							
	pe #s	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uence of):						
	cate be executed physician and the burial-transit	хап	that initiated events resulting in death) Last	Due to (or as a consequence	rence of):					_	
8760,	cate be execut physician and the burial-tran	m		000 10 (0. 00 0 00.000)							
387	phys phys the	dicai									
×	death certific e attending p d for use as	Physician/Me	IF FEMALE:	3c. If yes, outcome of pregna	incy				23d. Date	ol delivery	
Вох	atten for u	cian	in the past 12 months?	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	death 3	Ectopic pregnancy Other (specify)			Mont		ay Year
o.	the the	ysi	1 Yes 2 No 9 Unknown	9□ Unknown							
<u>α</u>	that the	Ph	Part II. Other significant conditions con	stributing to death but not res	ulting in the ur	nderlying cause give	en in Part I.	23e. Did to	bacco use contrib	ute to the	cause of death?
Vital Records,	The law requires that ite has been signed b page 2 should be deta	d by						1 🗆 Y	es 2□No 3	Probab	oly 4 Donknown
00	w requii been s should	ompleted						24a. Was a	24b. We	ere autops	v findings available
Re	The lay	ם						autops	sy pri med? de	ath?	y findings available pletion of cause of
a		e C	25. Was case referred to medical				00 Pl of Do	1 Yes		Yes 2	
₹		00	examiner?	lospital:	ER/Outpatien	Othe		ath (Check only or Home 5 Resid		/Conside	-
ō		2	27. Manual of Death	28a. Date of Injury	28b. Time of	1 3 DOX	4 Nuising i		ow injury occurred		
on	ding Ih. Th. After funer	Ş	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		(? Yes 2∐No				
Division	l or Attending after death. Director: After in by the fune	ertification;	3 Suicide 6 Could not be	28e. Place of Injury - At ho	ome, farm, str	eet, factory, office			treet and Number	or Rural F	Route Number,
Ö	Hospital or A 24 hours after Funeral Dire etely filled in b	ert	4 Homicide	building, etc. (Specify	v)			City or Town	n, State)		
	spits nours nera	ai C		sician: To the best of my kno							
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical	(Check only one) 2 Medical Examin	ner: On the basis of examina and manner stated.	tion and/or inv	vestigation, in my or	oinion, death occ	urred at the time, d	ate and place, an	d due to th	ie cause(s)
	To the within 2 To the complet	ž	29b. Signature and title of certifier	11		29c. License			9d. Date signed (
)	-		Salvador ,	Sprante 2	20	1400	53 927	7	Time 5	7,20	104
0	(7)		30. Name and address of person who co	empleted cause of death (Item	23a) (Type,	Print)		ref		1.	4
1	(2)		SALVADON Sylu			I Drin	r, ch	ry	Mary	MANO	1
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	iture						

		•	For State Registrar	State of Maryland / Depa <i>Ce</i>	artment of Health and N <i>rtificate of Death</i>	Mental Hygien Reg. N	2111b 2027b
			Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Death
н	Physicia /Medic		Margaret M.	Frink			004 11:40 AM
	Examin		4a. Facility Name (If not institution, give st.	reet and number)	4b. City, Town, or Location of Death	4	c. County of Death
			203 Broad Street		Pocomoke City		Worcester
	Funeral		5. Social Security Number 6. Sex 1 □	7, Age (In yrs. last birthday) M 2∑ F Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	
	Director		299-18-0674 Usuel Residence of Decedent	82		July 22, 1	1921 Ohio
	land		10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits
	Man	ţ	Maryland Worcester	Pocomoke	City		1 X Yes 2 □ No
	r 28s	Director	10e. Street and Number		10f. Zip Code	10g. C	Citizen of What Country?
	th wit	a D	203 Broad Street		21851	US	A
	within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28e-f ehow he Madical Eventil er mail be notified at	Funeral	11. Marital Status	2. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	or it		1 Never Married 2 Married 3 XWidowed 4 Divorced	17 Yes 2 No Navy If Yes, Give Wave	1 ☐ Yes 21 No Specify:		Specify:
215-0036	hour tural	Completed by	15. Decedent's Educa	Year or Dates: 1943–46	dent's Usual Occupation	16b.	White Kind of Business/Industry
7.	in 72 in 72 fedic	olet	(Specify only highest grade	completed) (Give	kind of work done during most of work DO NOT use retired)	king	,
212	d with jiene.	E O	Elementary/Secondary (0-12)	College (1-4or 5+) Phot	cographer	P	roduction
	be filed within 72 hours after death with the Marylan tal Hygiene. d other then "natural", or items 23s or 28s-f show event, the Medical Examination must be multified at	Bec	17. Father's Name (First, Middle, Last)			e (First, Middle, Maide	en Surname)
<u>a</u>	ould be Menta arked atic ev	TO B	George	Funk	Russel	la	 Spinnenweber
Maryland	2 should be filed v n and Mental Hygie 'is marked other t raumatic event, Ib	5 8	19a. Informant's Name/Relationship (Typ	e, Print) 19b. Mail	ing Address (Street and Number or Rui	ral Route Number, City	or Town, State, Zip Code)
	5 # 12 T		<u> John William Frink</u>		Broad Street, Poc		
ore	ges 1 au t of Hea If item or othe		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Re	moval from State 20b. Place of Dispose cemetery, cre	matory or other place)		Location - City or Town, State
Ë	Pages ment of I lant; If its jury or o	١.,	* 4 ☐ Donation 5 ☐ Other (Specify)	Salisbury		14, 2004	Salisbury, Maryland
Baltimore,	permit. Pages Department of Important: If i eny injury or once.		21. Signature of Funefal Service Licensed	i i	2. Name and Address of Facility Holloway Melson Fu 103 Linden Avenue,	neral Home Pocomoke	P. A. City, Maryland 21851
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death. Do not en			Approximate Interval Between
	Physician	4 0	Immediate Cause (Final disease or condition	Metantal	u Makanm	* Melen	Onset and Death
	/Medical		resulting in death)	Due to (or as a consequence of):	J		8110
	Examiner		Sequentially list conditions, b.				
	sit sit	lner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a consequence of):			
	and I-tran	Examin	that initiated events c. resulting in death) Last	Due to (or as a consequence of):			
68760,	icate be executed physician and s the burial-transit	ᄪ		,			
387		dical	d.				
Box (law requires that the death certific as been signed by the attending t 2 should be detached for use as	N/W	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregnancy	7-		23d. Date of delivery
B	death a atter d for u	Physician/M	in the past 12 months?	4☐Pregnant at time of death 5	☐Ectopic pregnancy ☐ Other (specify)		Month Day Year
P.O.	the cay the ached	hys	9 Unknown	9□Unknown			
	uires that the dea signed by the a Id be detached fo	by P	Part II. Other significant conditions cont	ributing to death but not resulting in the t	underlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?
ğ	w require been sig should b	ed				1 🗌 Yes	2 No 3 Probably 4 Munknown
Records,	aw requ is been 2 should	Completed				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
æ	The law ate has page 2	mo;				performed2	death?
Vital	ilcien: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?		26. Place of Dea	th (Check only one)	
of V	Physicien: r this certifica ral director, I	2	1 ☐ Yes 2 No	ospital: 1 Inpatient 2 ER/Outpatie		ome 5 esidence	
0	ding Pl		27. Manner of D⊸ th 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time (Work?	28d. Describe how in	jury occurred
sio	Attending r death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be		M 1 Yes 2 No	206 Lagatine (Ctreat	and Number of Board Board Number
Division	or At after d Direct in by	Certification;	4 Homicide determined	28e. Place of Injury - At home, farm, si building, etc. (Specify)	treet, factory, office	City or Town, Sta	and Number or Rural Route Number, ate)
	Hospital 24 hours a Funeral tely filled	2	29a. Certifier TV Certifying Physi	cien: To the best of my knowledge, dea	th occurred at the time, date and place,	and due to the cause	(s) and manner as stated.
	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical		er: On the basis of examination and/or in and manner stated.			
	To th To th comp	×	29b. Signature and title of servicer	>	29c. License number	29d. D	Date signed (Month, Day, Year)
)			1016	mi	00109	2	0/10/09
ا ۽	1,311		30. Name and address of person who cor	mpleted cause of death (Item 23a) (Type	Print) E. CARROL	ist.	SANSBURY MO
	Sta		31. Date filed (Month, Day, Year)	32. Angistrar's Signature	Sparte		(
	Regist	di	JUN 1 1 20	U4 REMEMBER SEE			

			1 _ State	State of Ma	ıryland		artment of H		Mental H	ygiene	9	
		_	Ragistrar 1. Decedent's Name (First, Middle, L	actl		Cer	unicate of L	Jean	2. Date of D	Rag. No	2004-	20275
	Physici	an		_	roals				Month	Da		0.2.4.1 M
>	_/Medic		Margare 4a. Facility Name (If not institution, g		LOCK		4b. City, Town, or	Location of De	June	11,	2004	0241 M
	Examin	er							alli			
	Ermanal		130th St. Parl 5. Social Security Number 6.	Sex 7. Age	(In yrs. la	ast birthday)	Ocean If Under 1 Year	If Under 24 H	rs. 8. Date of B		orceste 9. Birthp	lace (State or Foreign
	Funeral Director		215-52-0402	1 □ M 2 💢 F	56	Yrs.	Months Days	Hours Mi	in. $1-27$		MD Couin	try)
	ъ		Usual Residence of Decedent									
	rylan	_	10a. State 10b. County		10c. City	, Town or Lo					1	0d. Inside City Limits
	Ba-1 s	ct	Md. Worce	ster		Ucea	n City					1 XXes 2 No
	ith th or 24	Director	10e. Street and Number				10f. Zip Code			10g. Ci	tizen of What Coun	try?
	ath w	<u>ra</u>	13403 Coastal		135			1842		US		
	er de Items	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		S. 13. \	Was Decedent of His f Yes, specify Cubar	spanic Origin? n, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)	lo-	 Race - Americ Black, White, 	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 🍎 🎾 ivorced	1 □ Yes 2 → H If Yes, Give Year or Dates:	O		1 □ Yes 2√2 No	Specify:			Specify: Wh	ite
8	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or flems 23a or 28a-f show int, the Madical Examinar must be motified at	edi	15. Decedent's			16a. Deced	ient's Usual Occupa	ition		16b. K	(ind of Business/Inc	
21215-0036	n "n n	Completed	(Specify only highest g	rade completed)		(Give life. L	kind of work done d DO NOT use retired)	uring most of w	vorking			ŕ
212	y with	E	12	College (1-4or 5-	*	Bus	Driver			Pub	lic Tra	nsportati
פ	othe othe vant,	Be C	17. Father's Name (First, Middle, Las	st)				18. Mother's N	ame (First, Middl	e, Maider	Sumame)	
<u>a</u>	uld b Ments rrked ritic e	To	George M. Dori	n				Mary	M. Hel	wig		
Maryland	2 sho and is mu		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address (Street a	nd Number or	Rural Route Num	ber, City	or Town, State, Zip	Code)
≥,	and ealth m 27 ner tr		Richard W. Josi	ck (son)	los: Di		old No	rth Po	int Rd.			
0	ges 1 t of H If ita or oti		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	☐Removal from State	_ ce	emetery, cren	sition (Name of natory or other place				ocation - City or To	wn, State
Ē.	tmen tmen tant:		`4 Donation 5 ☐ Other (Spec		Sui		lem. Park		/15/2004	Re	rlin, MD	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or flems 23a or 28a-1 show any injury or other traumatic evant, the Madical Examinating must be notified at anone.		21. Signature of Funeral Service Lic	ansee 2 of his	4		. Name and Addres				Funeral	Home
_	40200		28a. Part1. Enter the disease, or co	delications that based	the death		8 William				21811	Approximate
			shock, or heart ailure. List on Immediate Cause (Final	y one cause on each line	6.	. 201101 0111	or the mode of dying	,, 00011 00 00.0	ac or respiratory	u., 031,		Interval Between Onset and Death
	Physician / /Medical		disease or condition resulting in death)	_aC+15_								
	Examiner			Due to or as a	i consequ	ience or):						
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequ	ence of):						
	uted d ansit	Examiner	cause. Enter Underlying Cause (Lisbase or injury that initiated events	· HT	3							
ó	exec an an rial-tr	Exa	resulting in death) Last	Due to (or as a	consequ	ence of):		-				
8760,	icate be executed physician and s the burial-transit	dlcal		d								
Θ	rtifica ng ph as th	Med	IF FEMALE:									
Вох	ith ce tendi	an/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1☐Live birth 2		death 3	Ectopic pregnancy				23d. Date of delive Month	ry Day Year
o.	res that the death certifi igned by the attending be detached for use as	by Physiclan/Me	1 ☐ Yes 2 ☑No 9 ☐ Unknown	4□Pregnant at t 9□ Unknown	time of de	eath 5□	Other (specify)				IN STILL	Day (Gai
<u>ď</u>	hat th d by detacl	P	Part II. Other significant conditions	contributing to death but	it not resu	Iting in the ur	aderiving cause give	n in Part I	23e Did	tobacco	use contribute to th	e cause of death?
ds,	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	1 by	NIDOM	dominous in ground and a second		many in the di	racity mg daddo givo			Yes 2		
Ö	w requir been si should	etec							-			
Division of Vital Records,	e law has l	Completed							24a. Wa auto	s an opsy formed?	prior to con death?	psy findings available appletion of cause of
<u></u>			OF IN-						1 ☐ Yes		1 ☐ Yes	2 □ No
⋚	ding Physician: The lav h. After this certificate has funeral director, page 2	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatier		ER/Outpatien	Othe	r	eath (Check only		o Man CAN	NO LOT
ō	Phy or this oral d	7: To	27. Manner of Death	28a. Date of Injury	y	28b. Time of	28c, Injury	at	28d. Describe		6 Other (S)
on	th. :: Afte	at lo	1 Natural 5 ☐ Pending 2 ☐ Accident investigat	(Month, Day	Year)	Injury	Work M 1 □ Y	? ′es 2∐No				
Vis	Atte	iffici	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ry - At ho	me, farm, str	eet, factory, office		28f. Location	(Street ar	nd Number or Rural	Route Number,
ā	safte safte al Dir	Certification;	4 - Hornicos	building, etc.	. (Specify	/			Only or 70	own, Otale	=/	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funaral Diractor: After this certific completely filled in by the funeral director.	Medical	29a. Certifier 1 Certifying I (Check only one)	Physicien: To the best of aminer: On the basis of	examinat:	vledge, death ion and/or inv	occurred at the time vestigation, in my op	e, date and pla inion, death oc	ce, and due to the curred at the time	cause(s , date and) and manner as sta d place, and due to	ated. the cause(s)
	To the within 2 To the Complet	Mec	29b. Signature and title of certifier	and manner stat	.eu.		29c. License	number		29d. Da	te signed (Month, L	Day, Year)
	F ≥ F ŏ						444	8581		6	111/04	
	1 -		30. Name and address of person wh	o completed cause of de	ath (Item			, ,	4	-	cal	
	1.5		Brockeller	Rider	1110	1 Kara	trade &	o bu	en no) 21	811	
	Sta Registr		31. Date filed (Month, Day, Year)	2004 32. Registra	ir's Signat	B. A	adel					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Munte 5, 2004 **Physician** 0310 A M Paul Ernest Green /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9440 Lanham Severn Road Prince George's Lapham If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral X** M 2□ F Months Director 217-98-9681 25 31, 1979 Wash., Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Exertiting mat be putified at Prince George's 1 X Yes 2 No Director Maryland Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7047 Palamar Turn 20706 United States Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ☐Yes 2/ No ō Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: by Specify: Black 3 Widowed 4 Divorced "naturel", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Il Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 12th Security Officer Self-Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be n and Mental h Pages 1 and 2 should be Paul E. Green, Sr. Robin Watson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul E. Green, Sr. - Father 5802 Junipertree Lane, Capitol Hgts., MD of Health other t Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. ö 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery | 6/10/2004 Brentwood, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC Part1. Anter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Programan /Medical Due to (or as a nsequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) by Physician/Medical IF FEMALE nse 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕻 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: $_{4\,\square\, \text{Nursing Home}}$ 5 \square Residence 6 \square Other (Specify) At Scene Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 XYes 2 ☐ No Certification: To in by the funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation ctshe Subn tree of o JOSOM 1 ☐ Yes s after death. 615104 death 2 Accident 6 Could not be determined 3 Suicide 4 Homicide 28e. Place of Injury At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 7440 Linken Steel behick Ford in loop, Mayla 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifies O.C.M.E. June 5, 2004

State Registrar HEYDORE MIKIN 2. Registrar's Signature

nd address of person who completed cause death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JUN 1 1 2004

,			1 - For State Registrar	State of M	aryland /			t of He	ealth ar			ene ⊩v⊗∏∏	JIC.	20277
	Physici	an	Decedent's Name (First, Middle	•						2	. Date of Death Month	Day	Year	3. Time of Death
	/Medic		Robert	Anison		ray					May 18,	2004		2:00 PM
	Examir	ner	4a. Facility Name (If not institution				4b. City,	Town, or t	_ocation of	Death		4c. County	of Death	
			Montgomery Gen			toda di Al	If Under	Olney		4 Hea La	- 15	Mon	gom	ery
	Funeral		5. Social Security Number 309-09-7592	6. Sex 7. Ag	ge (In yrs. last bi 86	Yrs.	Months	Days	Hours 24	Min	Date of Birth (Month, Day, Y	(ear)	9. Birth	place (State or Foreign intry)
	Director		Usual Residence of Decedent		00						June 9,	1917	Ind	iána
	/land		10a. State 10b. County		10c. City, Tov	wn or Lo	cation							10d. Inside City Limits
	Man Fed sh	tor	Maryland Montg	omery	В	rook	cevil]	le						1⊠Yes 2□No
	r 28g	Director	10e. Street and Number				10f. Zip	Code			10g	. Citizen of W	hat Cou	ntry?
	th wit	alD	3418 Briars R	oad				2083	3			US	SA	
	ems er - L	Funeral	11. Marital Status	12. Was Decedent Armed Forces		13. V	Was Deced	ent of His	panic Origin	n? (Specif	fy Yes or No- can, etc.)			can Indian,
90	or It		1 Never Married 2 Mar	ried 1 23 Yes 2 □	No		1 □ Yes 2		Specify:	T WORLD THE	san, otc.)	Specify:	, White,	, етс.
21215-0036	d within 72 hours after death with the Maryland jiene. r then "neturel", or Items 23a or 28a-f show Ite Medical Exaciliser must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:	42-45							Зреспу.	W	hite
5	"net	Completed	15. Deceden (Specify only highe	t's Education st grade completed)	16a	(Give	lent's Usua kind of won DO NOT us	k done du	ion I <i>ning most o</i>	of working	16	b. Kind of Bu	siness/Ir	ndustry
12	within ene. then *	mc d	Elementary/Secondary (0-12)	College (1-4or	5+)		nter	e reureu)				Govern	man	+
9	Hyge Hyge int.	မ င	17. Father's Name (First, Middle,	Last)					18. Mother's	s Name (F	First, Middle, Ma			
an	o d da	To B	James Anderson	Gray							ilson		7	
Maryland	s 1 and 2 should f Health and Men item 27 is marke other treumetic	-	19a. Informant's Name/Relations	hip (Type, Print)	198	b. Mailin	g Address	(Street an	d Number o	or Rural F	Route Number, C	city or Town. S	State. Zio	c Code)
	and 2 lealth a m 27 is		Jane Williams ·	- Daughter							eville M			,
ē,	s 1 a f Hez item othe		20a. Method of Disposition		20b. Place of	of Dispos		e of		Date		c. Location - 0		own, State
Ë	Page lent o nt: If ry or		1X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		Fort					5/21,	/2004 E	rentwo	od,	MD
Baltimore,	permit. Pages 1 a Dep-rtment of He Importent: If iten any njury or oth		21. Signature of Funeral Service			22	. Name and	d Address	of Facility	E.	ort Line			
Õ	Department of the sany in any		Meselent.	Klobast			3401	B1ad	ensbu:		oad, Bre			
*			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause	the death. Do	not ente	or the mode	of dying,	such as ca	rdiac or re	espiratory arrest	,	111	Approximate Interval Between
100	Pnysician		Immediate Cause (Final disease or condition		Intrace	ereb	ral B	leed						Onset and Death Days
	/Medical		resulting in death)	Due to (or as	a consequence	of):							-	Days
	Examiner	. 1	Sequentially list conditions,	0.	Cebrova		lar A	ccid	ent				1:	Lays
	be tis	Examiner	cause. Enter Underlying Cause (Disease or injury		a consequence	of)r							- 1	
	and and I-tran	хаш	that initiated events resulting in death) Last	U.	tension a consequence	of)-							-1.	Days
8760,	ate be executed hysician and the burial-transit	Ical E		500 10 (01 03	a consequence	01).								
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×	eath certific attending p for use as	Physician/Med	IF FEMALE:	23c. If yes, outcome	of pregnancy							23d. Date	of dollar	
Вох	atter atter	ciar	23b. Was decedent pregnant in the past 12 months?		2 Fetal death		Ectopic pre					Mont		Day Year
o.	that the ded by the detached	ysi	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown				/						
۳.	requires that the een signed by th hould be detache	by PI	Part II. Other significant condition	ons contributing to death b	ut not resulting i	in the un	iderlying ca	use given	in Part I.		23e. Did tobac	co use contrib	ute to th	ne cause of death?
Vital Records,	quires in signe		Pulmonary I	ibrosis						_ /	1 ☐ Yes	2 □ No 3	□ Prob	ably 4 🖺 Unknown
ပ္သ	> □ S	Completed	Bladder Car	ncer						i	24a. Was an	24b. W	ere auto	psy findings available
æ	0 4 9	шо					-			_	autopsy performed	d? de	ath?	mpletion of cause of
ī	i cien : Th certificate rector, pag	0	25. Was case referred to medical					- 2	26. Place of	Death (C	1 ☐ Yes 2 [Check only one)	INO IL	Yes	2 No
	dis ys	To B	examiner? 1 ☐ Yes 2 Mo	Hospital: 1 🛛 Inpatie	ent 2 ER/Ou	utpatient	3 DOA	Othor			5 Residence	e 6 🗆 Other	(Specifi	y)
n of			27. Manner of Death 1°⊠Natural 5 ☐ Pendin	28a. Date of Inju (Month, Da	y Year) 28b.	Time of Injury	28	lc. Injury a Work?			. Describe how i			
0	Attending r death. sctor: After by the funer	atic	2 ☐ Accident investig	gation			М		s 2 □ No					
Division		Certification:	3 ☐ Suicide 6 ☐ Could determ	ined 286. Place of Inj	ury - At home, fa c. (Specify)	arm, stre	et, factory,	office		28f.	Location (Stree City or Town, S	t and Number	or Rura	l Route Number,
Ω	lospitel of hours af unerel D													
	e Hospitel 24 hours a e Funerel I etely filled	edical	29a. Certifier 1 Certifyin (Check only 2 Medical one)	g Physician: To the best Examiner: On the basis o	f examination an	e, death ad/or inv	occurred a estigation, i	t the time, in my opir	, date and p non, death o	olace, and occurred a	due to the caus at the time, date	e(s) and mani and place, an	ner as st d due to	ated. the cause(s)
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	Mec	29b. Signature and title of certifie	and manner st			29c.	License r	number		29d	Date signed	Month	Day, Yearl
	- 3 F 8			1/1	\ / 1	۸,,,		Δ	15-	201	1	nau	111	
0.	Toll	/	30. Name and address of person	who completed cause of o	leath (Item 23a)	(Type =) nt)	ال	700	0 11	(WDC)	201	10	1, 2004
	MAN	9		othburt	Dri	VE	_, ^	Non	TGO	mE	24	Miles	70	AUT ADM
	Sta	te	31. Date filed (Month, Day, Year)		ar's Signature							V	/ _	, , , , ,
	Registr	ar	JUN 0 9 20	104	K. A	234								

			_ For	State of Ma	ryland / Dep	artment of H	lealth and N	•	•	
			1 - State Registrar		Ce	rtificate of L	Death		g. No. 7	00070
	Physicia		1. Decedent's Name (First, Middle, La Alvin Maur	rice Gamble				2. Date of Death Month May	Day Year 2004	3. Time of Death O
	/Medic Examin		4a. Facility Name (If not institution, gir	ve street and number)		4b. City, Town, or	Location of Death		4c. County of Death	
	LXamiii	CI	Malcolm Grow	Medical Cer	nter	Cam	p Spring	S	Prince	George's
	Funeral		5. Social Security Number 6.	Sex 7. Age	(In yrs. last birthday)		If Under 24 Hrs.		Year) 9. Birth	place (State or Foreign intry)
ı	Director		577-74-0412	1 X M 2 □ F	49 Yrs.	Months Days	Hours Min.	Feb. 22	, 1955 Sout	h Carolina
	pu ,		Usual Residence of Decedent		10a Ch. Taur					
	death with the Maryland ms 23a or 28a-f show r nutst be notified at	-	10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits 1 □XYes 2 □ No
	Ba-f	Directo		George's		Forestvi	.11e	17.		
	with ti	E	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co.	
	s 23e	rai	2809 Crestwi				20747			States
	er de Itam	Funerai	11. Marital Status	12. Was Decedent E Armed Forces?	verin U.S.	Was Decedent of Hi If Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	14. Race - Amer Black, White	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2X No If Yes, Give Year or Dates:		1□Yes 2□XNo	Specify:		Specify: B	Lack
15-0036	within 72 hours after ene. then "natural", or ita		15. Decedent's E		16a, Dece	dent's Usual Occupa	ation		6b. Kind of Business/I	ndustry
15	in 72	Completed	(Specify only highest gi	ade completed)	(Give	kind of work done of DO NOT use retired	during most of work	ring		,
212	d with jiene r tha	E	Elementary/Secondary (0-12)	College (1-4or 5+		intenance	/Contrac	tor	Priv	ate
2	be filed within 72 hours after death with the Marylar ital Hygiene. Ind other then "naturel", or frams 23a or 28a-f show ovent, the Medical Examination or its be notified.	Bec	17. Father's Name (First, Middle, Las	t)	, , , , , , , , , ,			e (First, Middle, M		420
<u>a</u>	should be and Mental s marked o umatic eve	To B	Henry W. C	Gamble				Margare	t Lewis	
Maryland 2121	2 should be and Mental is marked (raumatic ev		19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Street a	and Number or Rur	al Route Number,	City or Town, State, Z.	p Code)
	D = 2.1		Marthetta Gamb	le - Sister	c 1	201 Truma	in Ct., W	aldorf, N	MD 20602	
Baltimore,	ges 1 av 1 of Hea 1f itam or other		20a. Method of Disposition	75 11 011	20b. Place of Disponentery, cre	osition (Name of matory or other place		Date 2	Oc. Location - City or T	own, State
Ĕ	Pages nent of int: if it		1 ☐ Burial 2 ☐ Cremation 3 [`4 ☐ Donation 5 ☐ Other (Spec	_Hemoval from State		Crematory		2004	Clinton,	MD
a	그 돈 뿐 글	. 1	21. Signature of Funeral Service Lice	n e	2	2. Name and Addres	s of Facility St	ewart Fu	neral Home	
m	permi Depa Impo any ii		Nohu I.	Lepaix.		4001 Be	nning Rd	., N.E. V	Wash., DC 2	20019
			23a. Part Enter the disease, or cor shock or heart failure. List only	nplications that caused	he death. Do not en	ter the mode of dying	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease of condition		ac Arrest					Onset and Death
	/Medical		resulting in death)	_ a	consequence of):					
	Examiner		Comment H. Park and Philosophic	Cardi	o Myopathy	7				
		ner	Sequentially list conditions, if any, leading to immediate cause. Linter funderlying Cause (Disease or injury	Due to (or as a	consequence of):					
	cuted nd ransi	Examiner	that initiated events	C						
,09/	ate be executed nysician and he burial-transit		resulting in death) Last	Due to (or as a	consequence of):					
-	ate br	lical		d						
89)	ing p	Mec	IF FEMALE:							
Box	The law requires that the death certificat ate has been signed by the attending phy page 2 should be detached for use as the	by Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2	Fetal death 3	Ectopic pregnancy			23d. Date of delive	ery Day Year
0.	at the dea by the a tached fo	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at t 9□Unknown	ime of death 5[Other (specify)				Ju, 132.
<u>.</u>	d by detacl	Ph)	Part II. Other significant conditions	contributing to death but	t not reculting in the	andorhing cauca awa	on in Part I	23e Did tob	acco use contribute to	the cause of death?
က်	ires t signe I be d		Takin other diginioant containers	solution and to addition	thot looding in the c	indonying adda give	or are are i.		s 2 □ No 3 □ Pro	
Records,	w requires that been signed b should be deta	Completed						-		
Ş Ş	e faw has t je 2 s	ηpi						24a. Was an autopsy perform	prior to co	opsy findings available ompletion of cause of
=	ysician: The is certificate hadirector, page								No 1 ☐ Yes	2 No
Vita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:	v	othe Othe		h (Check only one		
	Phys this	-T	1 ☐ Yes 24 No 27. Manner of Death	1 ☐ Inpatien			4 - Nuising no	ome 5 Resider 28d. Describe how	nce 6 Other (Speci	(fy)
כ	Jing After funer	ion	1 Natural 5 ☐ Pending	(Month, Day	Year) Injury	Work	(? Yes 2 □ No	200. Describe not	w injury occurred	
S	Attandi death. ctor: A y the fu	ical	2 Accident investigate 3 Suicide 6 Could not	De Ose Blace of Injur	ry - At home, farm, st			28f. Location (Str	eet and Number or Rur	al Route Number
Division of	al or Attanding P safter death I Diractor: After t d in by the funera	Certification:	4 Homicide determined	building, etc.	(Specify)	out, lactory, office		City or Town,		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier 1 Certifying P	hysician: To the best of	f my knowledge, deat	h occurred at the tim	ne, date and place,	and due to the car	use(s) and manner as	stated.
	24 h 24 h a Fur etely	Medical	(Check only 2 Medical Exa	miner: On the basis of and manner state	examination and/or in	ivestigation, in my op	oinion, death occur	red at the time, da	te and place, and due	o the cause(s)
	ro th vithin ro th	Me	29b. Signature and title of certifier			29c. License	number	29	d. Date signed (Month,	Day, Year)
•			122	are o		D	17461	′	5/28/1	94
	(2)		30. Name and address of person who	completed cause of de	ath (Item 23a) (Type,	Print)			1 -1	
-	S			. Zarate, M		Silver Hi	111 Rd	Forestvi	11e, MD 20)747
	Sta	te	31. Date filed (Month, Day, Year)	2. Registra	r's Signature					
	Registr	ar	JUN 0 7 200	4 Elien	N Apo	W.				
-					-					

		State Registrar 1. Decedent's Name (First, Middle, L.	#2 ^{State} of Mar Unpend	Ce	rtificate of	Death		Reg. No.	23 Time of Beath
Physicia /Medic		CEDRIC LEVO	ON GILMO	RE			JUNE	7, 200	
Examin		4a. Facility Name (If not institution, gi	OSPITAL CENT		4b. City, Town, c CHEVER			PRI	y of Death INCE GEORGES
Funeral Director			Sex 7. Age (I 1 1 1	In yrs. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Bir Mov 2	1962	Birthplace (State or Foreign Florida
aryland show	_	10a. State 10b. County		Oc. City, Town or Lo	ocation ellville				10d. Inside City Limits 1XXYes 2 □ No
ith the Marylar or 28e-f show	Director	MD Prince G		- MI CCIR	10f. Zip Code	4			What Country?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "neturel", or Items 23a or 28e-f show any injury or other treumetic event, It's Madical Examination and other treumetic event, It's Madical Examination and other treumetic event.	by Funeral	921 Westlake Dri 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 Tyes 2 No	2/17/81 Army 2/14/82	Was Decedent of Hif Yes, specify Cub	lispanic Origin? (S an, Mexican, Puerl	pecify Yes or No o Rican, etc.)	o- 14. Ra	S.A. ce - American Indian, ack, White, etc. fy: Black
nin 72 hou n "neture	Completed	15. Decedent's E (Specify only highest gi	Education ade completed)	16a, Dece	dent's Usual Occup kind of work done DO NOT use retire	pation during most of word	king	16b. Kind of E	Business/Industry
ed with ygiene ser the	Com	Elementary/Secondary (0-12)	College (1-4or 5+)	Cc	opier Tec				vate
ld be fill ental H ked oth ic even	To Be	17. Father's Name (First, Middle, Las Joseph A. Gilme				18. Mother's Nar Eth	ne <i>(First, Middle</i> nel Moor		me)
nd 2 shou alth and M 27 is mar r treumet		19a. Informant's Name/Relationship Jacqueline Gilmore			ng Address (Street Westlake				
Pages 1 a ent of Hez nt: If item ry or othe		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Spec	☐Removal from State	20b. Place of Dispo cemetery, crea Harmony M	matory or other plac	06/12	Date 2/2004		- City or Town, State
permit. F Departm Importer any injur		21. Signature of Funeral Service Lice		1	2. Name and Addre				Funeral Svcs. D.C. 20002
*		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	e death. Do not en	ter the mode of dyir	ng, such as cardiad	or respiratory a	rrest,	Approximate Interval Between Onset and Death
Physician /Medical Examiner		disease or condition resulting in death)	a. Cocaine r		gitated d	elirium (iuring p	olice a	rrest
uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a co	onsequence of):					,
be icia bur		that initiated events resulting in death) Last	Due to (or as a co	onsequence of):					
Attending Physicien: The law requires that the death certificate trideath. sctor: After this certificate has been signed by the attending physic the funeral director, page 2 should be detached for use as the beautified.	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)	′			ate of delivery onth Day Year
uires that the signed by Id be detact	d by Pr	Part II. Other significant conditions Atherosclerotic	_		, ,	en in Part I.		obacco use con Yes 2 \(\subseteq No	tribute to the cause of death? 3 Probably 4 Unknown
The law require	omplete							an 24b. Dsy med? 2 \(\text{No} \)	Were autopsy findings available prior to completion of cause of death? VS 2□ No
certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:	V	oth 3 DOA Oth	26. Place of Dea	th (Check only o	nne)	
ding Phys h. After this funeral di	tlon; To	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury		at 28c. Injur	4 - Nursing H		became	unresponsive
afte Dir	Certification;	investigation Could not lead to the determined determined	00 - 016 (minus)	12:45 - At home, farm, str Specify)		X	while re 28f. Location (S City or Tov Campus	Street and Nuclean, State)	ed entral ^{ro} #ve ^{mbe} and rgo, Md
To the Hospitel within 24 hours a To the Funeral completely filled	Medical C	29a. Certifier (Check only one) 1 Certifying P 2 Medical Exa	hysician: To the best of m miner: On the basis of ex and manner stated	amination and/or in	h occurred at the tir vestigation, in my o	ne, date and place pinion, death occu	, and due to the tred at the time,	cause(s) and ma	anner as stated
To the within 2 To the complet	Me	29b. Signature and title of certifier	wah 6	19-	29c. Licens	e number		29d. Date signe JUNE	d (Month, Day, Year) 7, 2004
(1)1	1	30. Name and address of person who		h (Item 23a) (Type,	Print)	Baltimo	ro Marx	rland 21	201
1) Va		CABINII.A	4 14	TIT ICII	II DILLOCL,	рателио	re, mar	Tana Zi	1201

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician TUKE TRICIA 04 /2 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOUSE MONTEUMER y Numbe If Under 1 8. Date of Birth (Month, Day, Ye Sept. 13, 7. Age (In yrs. last birthday 194<u>3</u> Funeral 10 M 20 F California 503-48-9051 60 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location show 10a. State 10b. County 10d. Inside City Limits 1 and 2 should be filed within 72 hours after death with the Maryla Health and Mental Hygiene.
The Rat 7 is marked other then "neturel", or items 23s or 28s-f show the required event, it is had for items to make a continual to markle and the profiles of the second of 1 ☐ Yes 2 No Directo Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20814 USA 4710 Bethesda Ave. #416 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 ☐ Widowed 4 N Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) National Museum Curator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elsa G. Erickson Harold Gerhardt Peck 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2:3 Department of Health ar Importent: If item 27 is any injury or other treu once. Elsa G. Peck/ mother 205 W. 18th Street Sioux Falls, SD 57105 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State June 14, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Arundel Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2004 Odenton, Maryland 21. Signature of Funeral Service Licensee Going Mames Cremation Service P.O. Box 784 Leva Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician 4 months Uterine Leiomyosarcoma /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical attending ph for use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f signed by the pet 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 1 Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 No Hospitel or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: $_{4}$ Nursing Home $_{5}$ Residence $_{6}$ Nother (Specify) Hospice 1 ☐ Yes 2 📉 No this After the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred Injury 1 Natural 2 Accident 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) illed in by 4 | Homicide within 24 hours a 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) June 12, 2004 D45452 he 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) sistrar's Signature Prince Philip Dr. #327 Olney, MD 20832 C. Rajagopal M.D.
31. Date filed (Month, Day, Year) 18111 State JUN 1 4 2004 Registrar

		•	For State of Ma	ryland / Depa	artment of H		ental Hygier Reg. 1	2004	20281
	Physicia	_	1. Decedent's Name (First, Middle, Last) Robert A, Gregson				2. Date of Death Month	Day Yeer 9 2004	3. Time of Death 37
	/Medic Examin	_	4a. Fecility Name (If not institution, give street and number) Deer's Itead Can	tor	4b. City, Town, or Salish	Location of Death		4c. County of Deeth W, Cem; C	ð
	Funeral Director		212-20-3371 1SM 2□F	(In yrs. last birthday)	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye. 12-12-	ar) Coun	lece (Stete or Foreign try) A •
	Maryland is show	tor	Usual Residence of Decedent 10a. State 10b. County Md. Worcester	10c. City, Town or Lo	ocation n Pines			1	0d. Inside City Limits 1 ⊊ Yes 2 ☐ No
	with the 3a or 28a	Funeral Director	10e. Street and Number 98 Robin Hood Trail		10f. Zip Code 21811		_	Citizen of What Coun	try?
36	be filed within 72 hours after death with the Maryland ital Hygiene. of other than "natural", or items 23e or 28e-f show event, the Medical Exertiner must be notified at	by Funera	11. Marital Status 1 Never Married 2 Marned 1 Never Married 2 Marned 3 Widowed 4 Divorced 12. Was Decedent E Armed Forces? 1 Styes 2 N If Yes, Give Year or Dates:	0	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 2 No	spanic Origin? (Spec n, Mexican, Puerto R Specify:	city Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Wh	
3altimore, Maryland 21215-0036	ithin 72 hou ne. nen "nature ne Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5-	(Give	DO NOT use retired	turing most of working	g	. Kind of Business/Inc	
and 21	b la b	To Be Cor	12 17. Father's Name (First, Middle, Last) Robert W. Gregson	Saret	cy Servi	18. Mother's Name		den Sumame)	C
Maryl	1 and 2 should be fi Health and Mental F tem 27 is marked of other traumatic even	Ĭ	19a. Informant's Name/Relationship (Type, Print) Margaret V. Gregson			and Number or Rural	Route Number, Cit	ty or Town, State, Zip ines, Md	
imore,	8 0 E F		20a. Method of Disposition 1 □ Burial 2 ☑Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	Salisbu	matory or other place ry Crema	tory 6	-11 Sa	Location - City or To	
Balt	permit. Pag Department Important: any Injury o		21. Signature of Funeral Service Lensee]	10902 Ocea	ss of Facility U11 an Gateway	Berlin,		
•	Physician /Medical		23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin immediate Cause (Final disease or condition resulting in death) Due to (or as a	Prational aconsequence of:					Approximate Interval Between Onset and Death
8760,	Examiner physician and the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c. DYDG	a consequence of):	parking supra:	umonia osons d nuclear	r palsy	/	10 years 4 years
9	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetel death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of delive Month	ory Day Year
rds, P	w requires that s been signed b should be deta	by	Part II. Other significent conditions contributing to death but	it not resulting in the i	underlying cause give	en in Part I.	23e. Did tobacc	co use contribute to th	_
Reco	The law re- cate has bee page 2 sho	Completed					24a. Was an autopsy performed	2 death?	psy findings available inpletion of cause of 2 No
Division of Vital Records, P.O. Box	ding Physician: Th h. After this certificate funeral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatie 27. Manner of Death Manner of Death Month, Day	nt 2 ER/Outpatie		y at 2		o 6 □Other (Specify	()
Division	or Attendir after death. Director: Af In by the fu	Certification:	2 Accident investigation	ury - At home, farm, si c. (Specify)		Yes 2□No	18f. Location (Street City or Town, St	t and Number or Rura tate)	l Route Number,
_	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of 2 Medical Examiner: On the basis of and manner sta	of my knowledge, dea examination and/or ii ited.	ith occurred at the tin nvestigation, in my o	ne, date and place, a pinion, death occurre	and due to the cause and at the time, date	e(s) and manner as st and place, and due to	ated. the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier Ly () M	.D	D /C	3 number 3	29d.	pate signed (Month,	Day, Year)
ET	10+1		30. Name and address of person who completed cause of d	eath (Item 23a) (Type), Print) OX 2018	, Salis	bury.	MD 2/6	PO2
	St Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registra	ar's Signature	Carles				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item/26 per State of Maryland / Department of Health and Mental Hygiene Phy. 6/10/04 RM 1- State AACo. Health Dept. Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death nav Month **Physician** 03 2004 3:45 AM JUNE Dorothy E. Goodhand /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Annapolis Anne Arundel Medical Center Anne Arundel 8. Date of Birth (Month, Day, Year) NOV. 12, 1918 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2√2 F 85 Yrs. 217-05-0173 MD Director Usual Residence of Decedent 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28e-f show The Medical Examinant for cutified at Anne Arundel MD Annapolis 1 Tyes 2X No Direct 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1178 Idlewild Drive 21401 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Marned White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ð 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Business Administration Secretary 12 other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental P Pages 1 and 2 should be Thomas D.C. Frantz Flora Matilda Gemmill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other treu
ance. Virginia T. Armetta/Niece 1605 Dennis Avenue, Towson, MD 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Jun. 7, Burial 2 ☐ Cremation 3 ☐ Removal from State Sudlersville Cemeterv Sudlersville, MD 1 4 ☐ Donation 5 ☐ Other (Specify) 2004 22. Name and Address of Facility Barranco & Sons, 21. Signature of Funeral Service Licens P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. P.nt. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s ock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immed, to Cause (Final disease or condition resulting in death) Physician aCHRONIC OBSTRUCTIVE PULMONARY DISEASE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of) Box 68760. Completed by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 No 9 Unknown o 9 Unknown Division of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 Yes 2 No 1 Tes 2 No or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Other: 10 Alureing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No s after death.
I Director: After this of in by the funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D57531 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Wear) Millerville My succe SEDI VEREYEMENWY

DHMH 17 Rev 1/200

State

Registrar

ORIGINAL

32. Refistrar's Signature

JUN 1 0 2004

T, WILLAM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death Reg. No) 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2004 William Gent /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Doctors Community Hospital Prince Georges Lanham If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Hours Min. 1 **X**M 2 □ F Yrs Director 531-40-3496 62 May 21, 1942 Washington Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 'natural', or Items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or flems 23a or 28a-1 shov any injury or other traumatic event. It a Medical Examinat must be nelliked at 1 ☐ Yes 2☐ No Directo Maryland Prince Georges Lanham 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6705 96th Avenue 20706 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 JYes 2 No If Yes, Give 162-165 Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No Specify: Specify: δ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Medical Doctor Internal Medicine 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Fredrick Holman Mary Catherine Bottorff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6705 96th Avenue Lanham, Maryland 20706 Dana Waggoner (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date June 14, 1 ☐ Burial 2 ② Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation Cotr. Stevensville, MD. 2004 22. Name and Address of Facility Adams Funeral & Memorial Care 21. Signature of Coneral 814 Bestgate Road Annapolis, Maryland 21401 M00982 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) arteursulirites Pnysician yreres /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Extra 1954, if Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the attending physician and hed for use as the burial-transit the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day detached for 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ eq 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed: 2 No 1 Yes 2 🗌 No or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 □ DOA 1 ☐ Yes 2 No Certification; To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: A investigation 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 1 To the Hospital fill ed Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Ateun JUNE 8, JON4 1 Coursen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 515 Main Street Suite 351 Laurel Md 20107 Steven Kemsen, MD

State

Registrar

31. Date filed (Month, Day, Year)

JUN 1 1 2004

		•	1 - For State Registrar	State of Mar		artment of F			giene	20281
	Physici /Medic Examin	cal	Decedent's Name (First, Mic Elizabeth A. Facility Name (If not institute)	McDivett	F	Tughlett 4b. City, Town, o	r Location of Death	2. Date of Deal Month June	th Day Year 5 2004 4c. County of Deat	3. Time of Death 07:45a ^M
F	uneral irector		Dorchester 5. Social Security Number 220–26–3157 Usuel Residence of Decedent	1 □ M 20€ F	pital In yrs. last birthday, O Yrs.	Cambri If Under 1 Year Months Days		8. Date of Birth (Month, Day) Feb. 21		ter hplace (State or Foreign ountry) nsylvania
Maryland	a-f ehow	ctor	10a. State 10b. Cour	chester 1	10c. City, Town or L Camb	ocation oridge				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
-0030 hours after death with the Maryland	of other then "neturel", or ltems 23a or 28a-f ehow event, the Madical Examiner must be notified at	by Funeral Director	2 Kiowa RD 11. Marital Status 1 Never Married 2 M 3 Widowed 4 Divorce	If Yes, Give	rer in U.S. 13.	10f. Zip Code 216 Was Decedent of H If Yes, specify Cubin 1□ Yes 2√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√			Consider	orican Indian,
VIZIS-0036 within 72 hours af	hen "neture e Medical E	ompleted	(Specify only high	dent's Education hest grade completed)	(Give	edent's Usual Occup skind of work done DO NOT use retired	during most of wor	king	16b. Kind of Business/	•
	ked other ti	To Be Col	11 17. Father's Name (First, Midd) Harold	22 McDivett		nomemaker	18. Mother's Nam	ne (First, Middle, i	<u>house</u> w Maiden Sumame) Phillips	
e, MG 1 and 2 Health a	if item 27 is marked or other treumatic ev	-	19a. Informant's Name/Relation Thomas Carter 20a. Method of Disposition	onship (Type, Print)	on_ 2794	St. Mic	and Number or Ru haels Rd.	ral Route Number Easton	r, City or Town, State, 2 Md. 21601 20c. Location - City or	Zip Code)
Baitimor permit. Pages Department of	portent y injury				Salishu	matory or other place ry Crema 2. Name and Addre	atory 6/	/5/04 nomas Fun	Salisbury meral Home,	, MD
Pny	sician		23a. Part1. Enter the disease, shock, or heart failure. L' Immediate Cause (Final disease or condition resulting in death)	or complications that caused the class only one cause on each line a.	ne death. Do not en		ng, such as cardiac	or respiratory arr		Approximate Interval Between Onset and Death
be executed	by sician and the burial-transit the burial-transit	dicai Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c.	consequence of): consequence of): consequence of):		1			1
ecords, P.O. BOX 587 law requires that the death certificate	y the attending phiched for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tii 9 ☐ Unknown	Fetal death 3	⊒Ectopic pregnancy ⊒ Other <i>(specify)</i> _	y		23d. Date of deli Month	ivery Day Year
ecords, P	been signed by the should be detached	þ	Part II. Other significant cond	ditions contributing to death but	not resulting in the o		ren in Part I. Disen Se		bacco use contribute to es 2 ☐ No 3 ☐ Pr	
ž ž	ate has page 2	Completed	Hypoth yroidism	· //	OSKOATI	(C.4.3, A)	nemiA		med? prior to death? 2 2 No 1 □ Yes	topsy findings available completion of cause of 2ID/b
UIVISION OF VITAL the Hospitel or Attending Physicien: 1	After this funeral di	atlon: To Be	25. Was case referred to med examiner? 1 Yes 2 Yo 27. Magner of Death Natural 5 Per 2 Accident inve	Hospital: 1 Appatient 28a. Date of Injury	28b. Time	of 28c. Injur	ner: 4 Nursing H		ence 6 □Other (<i>Spec</i> ow injury occurred	zify)
UIVISION itel or Attending	rel Director	Certification;	3 ☐ Suicide 6 ☐ Cou 4 ☐ Homicide dete	building, etc.				City or Town		
To the Hospi	To the Funeral Director: completely filled in by the	Medical		fying Physician: To the best of cel Examiner: On the basis of e and manner state (fifer	xamination and/or in	29c. Licens	opinion, death occu	rred at the time, d		to the cause(s)
2	Sta	ate.	30. Name and address of pers	son willo completed cause of dea	0. 1	Print) 60 B1	44615 amble 3	St Can	bridge	
	Regist		O NOR O	1 2004						

unpend item#23a,27,PER ME,G832,6/30/04eg Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Thomas W. Hagerty amend item#1,41state of Maryland / Department of Health and Mental Hygiene 04 - 3925AKG State Registrar Certificate of Death 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Thomas William Hagerty, Jr. **Physician** June 14, 2:02 P M 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Carroll Hospital Center Westminster If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F 49 Director 216–62–6899 Sept. 2 1954 Maryland Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b County 28a-f show Examinar must be notified at Westminster 1 ☐ Yes 2X No Maryland Carroll County Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21158 United States 2115 Mayberry Road 238 permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a any hijury or other treumetic event, the Medical Examinational once. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 ☐ Married Specify: white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Federal Government firefighter / E.M.T. 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Thomas W. Hagerty, Sr. Elizabeth List 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Hagerty / brother 2115 Mayberry Road Westminster, MD 21158 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State June 19 1 Burial 2 Cremation 3 Removal from State St. Joseph's Cemetery Taneytown, Maryland ¹ 4 □ Donation 5 □ Other (Specify) 2004 22. Name and Address of Facility Skiles Funeral Home 21. Signature of Fyrieral Service Licenses 136 East Baltimore Street Taneytown MD 21787 1 www 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atherosclerotic Cardiovascular Disease Pnysician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury Due to (or as a consequence of) Examiner sician and burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician the burial Box 68760, Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performed? 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 🔀 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **XX**Yes 2 🗌 No 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 5 Pending investigation 1 X Natural 1 🗌 Yes death. 2 🗌 No 2 Accident Director 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \(\text{Homicide} \) within 24 hours a To the Funeral C 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar

0

31. Date liled (Month, Day, Year) JUN 2 8 2004

29b. Signature and title of certifier

111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature

death (Item 23a) (Type, Print)

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

June 15, 2004

State of Maryland / Department of Health and Mental Hygiene Reg. No Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) Dev Month Physician HWANG BYUNGHOON 8:20pm 04 /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Fecility Name (If not institution, give street and number) Examiner Washington Hagerstown, HEALTH CAPE CENTER JULIA MANOR Hours Min. 8. Date of Birth (Month, Day Year) Jan 22, 1913 7. Age (In yrs. last birthdav) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days 214-08-8660 1**X** M 2□ F 91 Director North Korea Usuel Residence of Decedent 10c. City, Town or Location death with the Maryland 10b. County 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is merked other then "natural", or items 23s or 28s-f ehow any injury or other traumetic event, the Medical Examiner must be notified as MD Washington 1 Yes 2 No Clear Spring, Funeral Director 10f. Zip Code 10e. Street end Number 10g. Citizen of Whet Country? 2525 Rockdale Road 21722 Korea Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Asian Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: δ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Bank Elementary/Secondary (0-12) College (1-4or 5+) Accountant 12th grade 4 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Do Won Hwang Dae Hyun Kim 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan White P.O.BOX 70 Clear Spring, MD 21722 daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) June 14, Date 2004 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Clear Spring, MD Little Rose Hill Cem. 21. Signature Inneral Service Licensee 22. Name and Address of Facility Donald Edwin Thompson Funeral Home, Inc 23a. Partier the disease, or complications that caused the det h. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. P.O.BOX 310 Clear Spring, MD 21722 Approximate Interval Between Onset and Death **Physician** a. CHIRCING OBSTRUCTIVE PULMONARY DISENSE

Due to (or as a consequence of): Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner RENAL FAIL URR attending physician and for use es the bunal-trensit Attanding Physician: The law requires that the death certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown ģ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en autopsy performed' 1 Tes 2 X No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attanding Physi within 24 hours efter death.
To the Funerel Director: After this completely filled in by the funerel dir this 28e. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of 5 Pending investigation 1 Natural 1 □ Yes 2 □ No 2/1 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide 29a. Certifier 17-Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Yeer) 29b. Signature and title of certifier 23186 052323 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

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Registrar

KHALID WASGEM

31. Date filed (Month Bay 115 2004

DHMH 16 Rev 6/95

OPAL COURT

HAGTRSTOWN MD. 21740

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32. Signeture

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	Physicia		1. Decedent's Name (First, Middle, Last) Gerald Ca	admus HICK	KS .			N	ate of Death Nonth		Year	3. Time of Death	n M
	/Medic Examin		4a. Facility Name (If not institution, give str. Washington County F			4b. City, Town Hag	or Location of	of Death		4c. County of Wash	of Death	on	
	Funeral Director		217-10-2904	7. Age (In)	yrs. last birthday) 81 Yrs.	If Under 1 Yea Months Day		24 Hrs. 8. D Min. (A Apı	ate of Birth Month, Day, 11 24	,1923	9. Birthpl Count Mary	lace (State or Fore try) Land	aign .
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Washington	1 _	City, Town or Lo						10	0d. Inside City Lim	
	h with the	Funeral Director	10e. Street and Number 14 West Cemetery St	reet		10f. Zip Code	21734		10	g. Citizen of W $U \cdot S$.		try?	
980	hin 72 hours after death with the Maryland an "natural", or Items 23a or 28a-f show Medical Examinatin ust be Lodfled at	by	11. Marital Status 12 1 □ Never Married 2 ★ Married 3 □ Widowed 4 □ Divorced	. Was Decedent Ever in Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:	i	Was Decedent of If Yes, specify Co 1 ☐ Yes 2 ☑ N			res or No- n, etc.)		- America c, White, c		
21215-0036	d within 72 jiene. r than "na	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12) 0-12		(Give	dent's Usual Occ kind of work dor DO NOT use reta acher	ne during mos	it of working	1	6b. Kind of Bus	ecti		
Maryland ?	should be filed nd Mental Hygir marked other umatic event.	To Be C	17. Father's Name (First, Middle, Last) ${\tt Jerry} D .$	Hicks			18. Mothe		arl C	aiden Sumame arl	9)		
	nd 2 sh alth and 27 is m r traum		19a. Informant's Name/Relationship (<i>Type</i> Wilda E. Hicks — wi	fe	Pos	ng Address (Stre st Offic		1, Funk	kstown	, Maryl	and	21734	
Baltimore,	0 0 = =		20a. Method of Disposition 1 ※Burial 2 □ Cremation 3 □ Rer 4 □ Donation 5 □ Other (Specify)	noval from State	Rose Hi	natory or other p	tery	June 1 2004	4, I		own,	wn, State Maryland	d
Bal	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Licensee Find L. V. 23a. Part1. Enter the disease, or complica	stal	4 1		Wilson	Blvd.	Hage	rstown,		yland 21	74
8760,	Physician / Medical Examiner	lical Examiner	shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a cor	ISEQUENCE OF): DMGN/A Isequence of):				pratory uno			Interval Between Onset and Death	
O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pro 1 Live birth 2 4 Pregnant at time 9 Unknown	Fetal death 3	⊒Ectopic pregna □ Other (specify)				23d. Date Mon	of delive	ry Day Year	
<u>α</u>	quires that n signed b uld be deta	by	Part II. Other significant conditions contri	ibuting to death but not	t resulting in the u	nderlying cause	given in Part I	J. :	23e. Did toba		bute to th	e cause of death?	
Il Records,	40 TT	Completed							24a. Was an autopsy perform Yes 2	ed? de	/ere autoprior to coneath?	osy findings availal npletion of cause of 2 No	ble of
of Vital	ding Physician: Th n. After this certificate funeral director, pag	To Be	1 Tes 2 XIVO	7-1	2 ER/Outpatier	IL SU DOA	Other: 4 🗆 No		5 🗌 Resider	nce 6 Othe		·)	
Division o	tending leath. tor: After the funer	Certification:	27. Manner of Death 1	28a. Date of Injury (Month, Day Yea 28e. Place of Injury - building, etc. (S)	At home, farm, str	M 1	njury at Vork? Yes 2	No 28f. L				l Route Number,	
ā	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edical Cer	(Check only 2 Medical Examine	cien: To the best of my	knowledge, deat								
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner stated.		29c. Lice	ense number	3	29	d. Date signed	(Month, L	Jay, Year)	
	PH-101		30. Name and address of person who come in the come in	pleted cause of death	(Item 23a) (Type.	Print)	lagers	stown	Mar	yland			
	Sta Regist	ate rar	31. Date filed (Month Day Year) 4 200	32. Tegistrar's S	Signature	oute							

	Please	e Type or F	Print i	n Black l	Indelible	e Ink.	Ens	ure Al	II Copies	Are	Legible.		
For		State of	Maryl		•				Mental Hy	giene	÷		
State Registrar				С	ertificate	e of [Death	7		Reg. No	2006	20	288
1. Decedent's Name	(First, Middle, La	ast)							2. Date of De	ath Day	y Year	3. Tim	e of Death
GAIL L	LEA HAC	GEMAN							June	10	2004		55 A ^M
4a. Facility Name (If I	not institution, gi	ive street and nun	nber)		4b. City,	Town, or	Location	n of Death		4c.	. County of Dea	th	
REEDERS M						BOONS			T =(D			INGTON	
5. Social Security Nu		Sex 1 □ M 2 XF		yrs. last birthda O Yrs.	Months	Days	Hours	er 24 Hrs. Min.	8. Date of Birt (Month, Da	ı <i>y, Year)</i>	Co	ountry)	ate or Foreign
219-66-19 Usual Residence of I	929		4	8					JULY 29	1, I	955 NE	W MEX	ICO
	10b. County		10c	. City, Town or	r Location							10d. Insid	e City Limits
MARYLAND	WASHII	NCTON				ROOF	NSBOF	PΩ				10	Yes 21∏ No
10e. Street and Num		MOTON			10f. Zip		ADDOL	10		10g. Cit	izen of What Co	ountry?	
7518 MAPL		DΛΛD					2171	1 3			U.S.A	١	
11. Marital Status	TEATTE I	12. Was Dece		in U.S. 1	3. Was Decec	dent of Hi	ispanic O	Origin? (Spe	ecify Yes or No)-	14. Race - Ame	erican Indiar	n,
1 Never Marrie	ed 2 Married	Armed For 1 ☐ Yes	rces? 2⊠No		If Yes, spec	cify Cubar	ın, Mexica	an, Puerto	Rican, etc.)		Black, Whit	te, etc.	
3 ☐ Widowed 4		If Yes, Give Year or Da	/e		1 ☐ Yes 2	2 √ №	Specify	y :			Specify:	WHITE	₹.
	15. Decedent's E				ecedent's Usua			- at unoth	./	16b. K	ind of Business		
(Specif Elementary/Secon	ify only highest gi	College (1	-4or 5+)	life	ive kind of wor e. DO NOT us	se retired	uring mo	IST OF WORK	ing				
10					DIS	SABLE	ED				DISABI	ED	
17. Father's Name (F	First, Middle, Las	st)					18. Moth	ner's Name	e (First, Middle,	Maiden	Sumame)		
FRED EAR	RL HAGEM	AN					FERI	N LOU	ISE MAS	SEY			
19a. Informant's Nar	me/Relationship	(Type, Print)		19b. Mr	ailing Address	(Street a	and Numi	ber or Rur	ral Route Numbe	er, Cîty o	or Town, State,	Zip Code)	
WANDA H.	HEUER/A	UNT		7518	8 MAPLE	<u> VILI</u>	LE RO	JAD,	BOONSBO	RO,	MARYLAN	vD 21	.713
20a. Method of Dispo 1 ⊠Burial 2 □ 1 4 □ Donation	Cremation 3	□Removal from S	State	Db. Place of Dis cemetery, c	crematory or or	ther place		6/12/	Date / 2004		ocation - City or		
21. Signa ure of Fur	eral Servic - ice		1 M. I		22. Name an		ss of Faci		7606 01	ld N	ational Maryla	Pike	1713
23a. Part. Enter the shock, or heard immediate Cause (F disease or condition resulting in death)	rt failure. List onl (Final	y one cause on ea	ach line.	death. Do not o	ur-	de of dying			or respiratory a	rrest,			Between and Death
Sequentially list con if any, leading to immorause. Enter Under Cause (Disease or in that initiated events	nmediate urlying injury	b. Due to (or as a cor	nsequence of):									
resulting in death) La	.ast	Due to (or as a con	nsequence of):									
IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☑ 9 ☐ Unknown	menths?		oirth 2 □ I nant at time	Fetal death	3 □Ectopic pri 5 □ Other (sp						23d. Date of de Month	livery Day	Year
Part II. Other signific	icant conditions	contributing to de	ath but not	t resulting in the	e underlying c	ause give	en in Part	tl.	23e. Did to		use contribute to		of death?
									24a. Was autop perfo 1 🗆 Yes	psy ormed?	death?	utopsy findir completion	ngs available of cause of

Physician /Medical Examiner

physician

Physician

/Medical

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Murital Exit: in attribute the rivillied at once.

Be Completed by Funeral Director

use as the burial-transit cate has been signed by the attending page 2 should be detached for use as within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

dicai

Sequentially list any, leading cause. Enter l Cause (Diseas that initiated exresulting in dearesulting in dear Examiner Medical Certification: To Be Comple 25. Was case referred to medical examiner?
1 \(\text{Yes} \) Yes 2 \(\text{No} \) No 27. Manner of Death

Š	1
an/	2
Sici	
F.	_
Š	Р
ted	-

1 Natural 2 Accident

3 ☐ Suicide

29a. Certifier (Check only one)

4 Homicide

26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Nursing Home 5 Residence 6 Other (Specify)

28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. Robert

5 Pending

investigation 6 Could not be determined

> 29c. License number D32518

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

301-432-2222 Drive, Keedysville, Maryland 21756/

State Registrar

Guedenet 21 Wyand 31. Date filed (Month, Par Year) 4 32. Redistrar's Signature

28a. Date of Injury (Month, Day Year)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

			For State	State o	f Maryland / De			d Mental Hyg	iene	
			State Registrar 1. Decedent's Name (First, Middle)	0 (201)		ertificate of	Dealli	2. Date of Deat	ng. No	2 7 2 0 0
	Physicia	an	Picha and		altersley			Month T (ANE	Day Year 4 - 2004	- 21:50 M
	/Medic		4a. Facility Name (If not institution			4b. City, Town, o	r Location of De		4c. County of Death	
	Examin	er				Hagers				on County
	Funeral		Washington Co 5. Social Security Number	6. Sex	1.tal 7. Age (In yrs. last birthd	lf Under 1 Year	If Under 24 H	Irs. 8. Date of Birth in. (Month, Day,		pplace (State or Foreign
ш	Director		214-32-8592	X □M 2□F	67 Yrs	Months Days	Hours M			aryland
	p y		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	fanyla sho	ក								1 □ Yes ŽŽŪNo
	28a-1	Director	Maryland Washi	ngton	Hager	10f. Zip Code		16	0g. Citizen of What Co	untry?
	with 3a or		10616 Roberts	Lane		21742			U.S.A.	
	ms 2:	Funeral	11. Marital Status	12. Was Dec		3. Was Decedent of H	ispanic Origin?	(Specify Yes or No-	14. Race - Amer	
9	or Ita	Ē	1 ☐ Never Married 2 X Marr	ried 1 XYes If Yes, Gi	2 No	If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	Specify:	eno Hican, etc.)	Black, White	
03	72 hours after death with the Maryland netural', or Itams 23a or 28a-f show Itsal Examiner must be malified at	d by	3 Widowed 4 Divorced	Year or D	ates:					
21215-0036	d within 72 hours after death with the Marylan plan : r than "netural", or Itams 23a or 28a-f show It a Maribal Examinet must be notified at	Completed		t's Education st grade completed)	(G	cedent's Usual Occup ive kind of work done a. DO NOT use retired	during most of v	working	16b. Kind of Business/I	ndustry
12	within ene. than "	duc	Elementary/Secondary (0-12)	College (1-4or 5+)				Federal G	'ovornment
9	Hyg Hyg ant,		17. Father's Name (First, Middle,			omptroller		Name (First, Middle, A		OVELIMENT
an	D C T D	To Be	Frederick John	Hattersle	ey		Lill	ian Putter	:	
Maryland	A DE E		19a. Informant's Name/Relations	hip (Type, Print)	19b. M	ailing Address (Street	and Number or	Rural Route Number,	City or Town, State, Z	îp Code)
	s 1 and 2 of Health a itam 27 is other trai		Gwendolyn Jean	Hattersle	ey/Wife 106	16 Roberts	Lane H	lagerstown,	Maryland	21742
ore	ges 1 a of Hea If itam or othe		20a. Method of Disposition 1 Burial 2 X Cremation	3 Pemoval from	20b. Place of Di cemetery,	sposition (Name of crematory or other place	(e)	Date	20c. Location - City or 1	Town, State
Ĕ			`4 □ Donation 5 □ Other (S		Smithsb	urg Cremat	ory Jun	e 12, 04	Smithsburg	Maryland
Baltimore,	permit. Pag Department Important: I eny injury o		21. Signature of Funeral Service	Licensee ()	11 Does 10	22. Name and Addre 1331 Easte	ss of Facility D rn Blvd	ouglas A. 1. N. Hager	Fiery Fune stown, Mar	ral Home yland 21742
	- Stage		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the death. Do not					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	A.		- 5-0- cel	Tin	Carctic	300	One Lour
	/Medical		resulting in death)	a. Due to	(or as a consequence of):	410141	1-11.	TAICLE	7)	THE ROUT
	Examiner		Sequentially list conditions							
	P #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consequence of):					
	and trans	Examin	that initiated events resulting in death) Last	c.	(or as a consequence of):					
8760,	The law requires that the death certificate be executed to has been signed by the attending physician and te has been signed by the attending physician and tage 2 should be detached for use as the buriat-transit	calE	,	545 15	(5) 43 2 35/1354436/165 5/).				Ī	
687	icate physi s the I	glo		d						
×o	eath certific attending pl for use as t	Physician/Medl	IF FEMALE: 23b. Was decedent pregnant		tcome of pregnancy	- 55-			23d. Date of deliv	very
B.	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Preg	birth 2 ☐ Fetal death nant at time of death	3 □Ectopic pregnancy 5 □ Other (specify) _	′		Month	Day Year
P.0	that the d ed by the detached	hys	9 🗆 Unknown	9□ Unkr	nown					
	es tha igned be de	by F	Part II. Other significant conditi	ons contributing to d	1 1-	e underlying cause giv	en in Part I.		pacco use contribute to	
Records,	w require been si should b	ted	wegener	6-ran	1 omato	2512		1 Ye	s 2 No 3 Pro	obably 4 □Unknown
ec	e faw r has be je 2 sh	Completed	Chronic	Kenal	In suf-	Fiency		24a. Was ar autops	y prior to c	topsy findings available ompletion of cause of
H	G C	Con	Hyperten	sion				perform 1 □ Yes		2 No
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medica examiner?	Hospital:		tions 25 DOA Oth	or	Death (Check only on		
of	shys this al dii	P.	1 ☐ Yes 2 No 27. Manner of Death	28a. Date	Inpatient 2 ER/Outpa of Injury 28b. Tim	Hent 3 DOA	4 🗀 Nursin	g Home 5 Reside	ince 6 Other (Special in the following of the following o	ify)
	ding Ph h. After th funeral	tlon	1 Natural 5 Pendi	ng (Mor	nth, Day Year) Inju	y Wor	k? Yes 2 □ No		,,	
Division	or Attanding after death. Diractor: After in by the fune	flca	3 Suicide 6 Could	not be 28e. Plac	e of Injury - At home, farm	street, factory, office			reet and Number or Ru	ral Route Number,
Di	in the	Certification:	4 Homicide	build	ling, etc. (Specify)			City or Town	, State)	
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical (29a. Certifyir (Check only one)	Examiner: On the b	e best of my knowledge, doasis of examination and/onner stated.	eath occurred at the tir r investigation, in my o	ne, date and pla pinion, death o	ace, and due to the ca ccurred at the time, da	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	Fo the within Fo the comple	Me	29b. Signature and title of certifie			29c. Licens	e number	29	9d. Date signed (Month	, Day, Year)
.7	10+1		1/lemai	C. Ibus	wan Phil	MD Doc	1759	1 :	June 11	2004
5			30. Name and address of person	who completed cau	se of death (Item 23a) (Ty	pe, Print)			/)/
		-	George C. Neum	an Jr. 11	110 Malical (Registrar's Signature	ompus RO	Hager	stoum, M.	D 2174Q	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year JUN 14	2004	en B. A	pulle				

			1 - For State Registrar	State of Marylan		artment of H rtificate of			Rag. No	001	20200
	Physicia	an	Decedent's Name (First, Middle, Last					2. Date of De Month	aath — Day	2004	3. Time of Death
	/Medic Examin		Neal Eugene HAINE 4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of			County of Death	
	LXamiii	CI	Washington County	Hospital			rstown		V	Vashingt	on
	Funeral Director		5. Social Security Number 6. Se 10 10 11 10 11 10 11 10 11 10 11 10 11 10 11 11	x 7. Age (<i>ln yr</i> s. XIM 2□F 46	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. 8. Date of Bi	ay, Year)		place (State or Foreign Intry) Virginia
	and w	1	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
	Maryl f sho	ţo	W. Va. Berkeley	F	alling	Waters					1 ☐ Yes 2X No
	or 28a	Director	10e. Street and Number			10f. Zip Code	-		10g. Citiz	zen of What Cou	intry?
	ath will		2 Jeanna Lane			25419				J.S.A.	
136	filed within 72 hours after death with the Maryland Hygiene. the than "natural", or frams 23a or 28a-f show ont, the Medical Exandment instituted at	by Funerai	11. Marital Status 1 □ Never Married 2 ◯ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? M☐ Yes 2☐No If Yes, Give Year or Dates: 1975-		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No		n? (Specify Yes or No Puerto Rican, etc.)		4. Race - Amer Black, White Specify:	
5-0036	72 hou	ted	15. Decedent's Edu (Specify only highest grad	ucation	16a. Dece	dent's Usual Occup	oation	af working	16b. Kir	nd of Business/l	
2121	vithin 79.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)	, working		_	
2	e filed w Il Hygier other ti vent, Ill		12 17. Father's Name (First, Middle, Last)	0	Ya	rd Jockey		s Name (First, Middle	Maiden	Manufac	turing
and	0 0 ×	To Be	Samuel O'Neal Hai	nes				y Saunder		Samamoy	
Maryland	da mi	ř	19a. Informant's Name/Relationship (T)		19b. Mailir	ng Address (Street		or Rural Route Numb		Town, State, Zi	p Code)
	and 2 eaith a n 27 is		Sue Haines - Wife		2 Je	anna Lane	e Fall	ling Water			
Baltimore,	jes 1 an of Heal If Item 3 or other		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ F	Removal from State	emetery, crei	sition (Name of matory or other pla		Date	Lond	cation - City or T lenderry	own, State Township
=	trant of tant: If It ijury or o		* 4 ☐ Donation 5 ☐ Other (Specify)	Po		emetery			Bedfo	ord Co.,	Pa.
ga	permit. Pages Department of I Important: If It any injury or o		21. Signature of Funeral Service Licens		1 /	2. Name and Addre		Minnich Lvd. Hage			
	Pnysician :		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition	It actions that caused the deat ine cause on each line.	h. Do not ent	er the mode of dyin	ng, such as ca				Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					. 70.3
		iner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury	b. Due to (or as a conseq	uence of):						
8/60,	certificate be executed ding physician and use as the burial-transit	dicai Examiner	that initiated events resulting in death) Last	c. Due to (or as a conseq	uence of):						
9	rtificat ng phy as th	Medi	TETERNIE.								
O. Box	death e atter	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	death 3	Ectopic pregnanc Other (specify)	у		2	3d. Date of deliv	ery Day Year
J. O.	res that thighed by be detact		Part II. Other significant conditions co	entributing to death but not res	ulting in the u	nderlying cause giv	ven in Part I.	23e. Did	obacco us	se contribute to	the cause of death?
ecords,	law requires that the as been signed by th 2 should be detache	d by						1 🗆	Yes 2]No 3 ☐ Pro	bably 4 □Unknown
O O	law requiras as been si 2 should b	piete						24a. Was		24b. Were aut	opsy findings available
¥	0 L 0	Completed						— auto perfo 1 ☐ Yes	rmed?	death?	ompletion of cause of 2 No
Vital R	icien: Th certificate rector, pag	Be (25. Was case referred to medical examiner?	11				f Death (Check only	one)		
0	Physi this c	To.	1 ☐ Yes 2 ♠ No 27. Manner of Death	Hospital: 1 Inpatient 2 28a. Date of Injury	ER/Outpatier	IL SELDON	A POST OF THE PROPERTY OF THE	ing Home 5 Resi			fy)
0	ding h. After funer	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Wo	rk? Yes 2.⊟No		now injury	occurred	
Division	el or Attending Physicien: s after death. Il Director: After this certific ad in by the funeral director,	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, str (y)	eet, factory, office		28f. Location (City or To		l Number or Rur	al Route Number,
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	edicai (29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Example 1	vsicien: To the best of my kno iner: On the basis of examina and manner stated.	owledge, death	n occurred at the ti vestigation, in my o	me, date and opinion, death	place, and due to the occurred at the time,	cause(s) date and	and manner as a place, and due t	stated. to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	11: 11		29c. Licens		411		signed (Month,	
)	, 7		Somis the				520	04	06	-09-5	100 7
<	pit		30. Name and address of person who can sharp the state of	MD - 1/300,	PAL C	ourt of	4AGERS	TOUN IN	10	21740	7
	Sta Registr		31. Date filed (Month, Day, Year)	32. Régistrar's Signa	H. A	ale					

			riease	• •	/ Department of Health and N	-	ne			
		•	1 - State Registrar	Otate of Maryland	Certificate of Death	Reg. I				
			Decedent's Name (First, Middle, Last	st)		2. Date of Death Month	Day Yeer S. Time of Death			
	Physicia /Medic		Nancy Anne Henck			1	3 2004 [L2:10 A M			
	Examin		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death		4c. County of Death			
			21002 Mount Aetna 5. Social Security Number 6. S		Hagerstown birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Yea	Washington 9. Birthplace (State or Foreign Country)			
	Funeral Director			□M 20XF 66	Yrs. Months Days Hours Min.	08-24-193	37 Country) PA			
	/land		10a. State 10b. County	10c. City, T	own or Location		10d. Inside City Limits			
	a-fsh	ctor	MD Washingt	on Hag	gerstown		1 ☐ Yes 2 🛣 No			
	3 or 28	i Dire	10e. Street and Number 21002 Mount Aetna	Road	10f. Zip Code 21.742	10g. Citizen of What Country? USA				
36	permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show says inury or other traumatic event, the Medical Everal art must be notified at 2008.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 XDivorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race · American Indian, Black, White, etc. Specify: White			
12-00	"natura	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	6a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	sing 16b	Kind of Business/Industry			
2	withir iene. than	ошо	Elementary/Secondary (0·12)	College (1-4or 5+)	Computer Operator		Medical			
and 2	d be filad antal Hygi ted other c event, I	To Be C	17. Father's Name (First, Middle, Last) Troy Thomas Willi			Name (First, Middle, Maiden Sumame) n Elizabeth Ferguson				
Maryland 21215-0036	nd 2 shoul Ith and Me 27 is mark	ř	19a. Informant's Name/Relationship (Cheryl L. Scriver	** *		ural Route Number, City or Town, State, Zip Code) d, Hagerstown, MD 21742				
e,	of Healifam Starm		20a. Method of Disposition	20b. Plac	e of Disposition (Name of etery, crematory or other place)	Date 20c.	Location - City or Town, State			
Ē	Paga ment c ant: If ury or		1 ☐ Burial 2 🖾 Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify)	Smit	hsburg Cremator. 06/11	./2004 Sm:	ithsburg, MD			
Baltimore,	Depart Depart Import any in once.		21. Signature of Funeral Service Licer	nspe	22. Name and Address of Facility Ge 305 N. Potomac Str		innich Funeral Home			
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death. one cause on each line.	Do not enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between			
4	Pnysician	6. 1	Immediate Cause (Final disease or condition	a Dehydo	tion		Onset and Death 4 (1/5)			
	/Medical Examiner		resulting in death)	Due to (or as a consequer	Loteral Scherosis		21/4/100			
		ē	Sequentially list conditions, if any, leading to fin hodiate cause. Enter Underlying Cause (Disease or injury	b. Due to for as a consequen			- Tipe 13.			
	cuted	Examiner	that initiated events	c						
760,	e ba executed sician and e burial-transit	cal Ex	resulting in death) Last	Due to (or as a consequer	nce of):					
687	ficate physics the			_ d						
Вох	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat 9 ☐ Unknown	eath 3 Ectopic pregnancy		23d. Date of delivery Month Day Year			
, P.O.	that the hed by detact		Part II. Other significant conditions	contributing to death but not resulting	ng in the underlying cause given in Part I.	23e. Did tobacc	to use contribute to the cause of death?			
rds	quires an sign uld be	ed b	High Cholesters 1.			1 🗌 Yes	2₽No 3 Probably 4 Unknown			
9	law re as bee 2 sho	Completed by	Coronary Artery Visa		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of				
Ě		Соп	,			performed				
Vita	Phyaician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	Other	th (Check only one)	0 □015 × (0 × × 4)			
o	Phys r this aral di	T: To	1 Yes 2 No 27. Manner of Death		Bb. Time of 28c. Injury at	28d. Describe how in	6 ☐Other (Specify)			
ion	Attanding r death. actor: Atter	atio	Natural 5 Pending 2 Accident investigation		Injury Work? M 1 Yes 2 No					
Division of Vital Records,	tal or Attand s after death at Diractor: , ad in by the f	Certification;	3 Suicide 6 Could not be determined		e, farm, street, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)			
	To the Hospital or Attanding Phyaician: within 24 hours after death. To the Funaral Director: Atter this certific completely filled in by the funeral director.	Medical C	29a. Certifier to Certifying Pl (Check only one) 2 Medical Exa-	nysician: To the best of my knowle miner: On the basis of examination and manner stated.	edge, death occurred at the time, date and place, n and/or investigation, in my opinion, death occu	, and due to the cause rred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)			
	To the within To the complete	Me	29b. Signature and title of certifier	200	29c. License number		Date signed (Month, Day, Year)			
					D D-00 5641	3	6/8/04			
2	H-3		30. Name and address of person who		3a)(Type, Print) Williamsport, MD 21795					
		ate	31. Date filed (Month, Day, Year)	32. Registrar's Signatur	-		5			
	Doniel			2004 Beren D	. Bower					

		For	State of	Maryland / [-			Mental Hyg	iene	
		1 - State Registrar			Certific	ate of	Death	Re	g. No	20202
Physic	ian	Decedent's Name (First, Middle, TO GENERAL TO THE TERMINATE OF TH	,		_			2. Date of Deat Month	Day Ye	
/Med	ical	JOSEPHINE ELI 4a. Facility Name (If not institution,		HUNTZBERRY			and position of Door	June	7 200	
Exam	ner	WASHINGTON COUN			40. 0		or Location of Deat SERSTOWN	tn	4c. County of E	
Funera			S. Sex 7	7. Age (In yrs. last birt		der 1 Year	If Under 24 Hrs			INGTON Birthplace (State or Foreign Country)
Director		220-34-0883	1□M 2⊠F	91	Yrs. Mont	hs Days	Hours Min.	(Month, Day, MARCH 29	1913	MARYLAND
and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location					
Maryii f sho	0	,	INGTON	loor only, your	or coodion		DOOMODOD	10		10d. Inside City Limits 1 X Yes 2 □ No
the I	Director	10e. Street and Number	TINGTOIN		10f.	Zip Code	BOONSBOR		ng. Citizen of What	
h with		141 SOUTH MAIN	STREET			,	21713		U.S	•
ifter death with the Marylan ritems 23a or 28a-f show	Funeral	11. Marital Status		dent Ever in U.S.	13. Was De	cedent of H		Specify Yes or No-	14. Race - A	merican Indian,
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. than 'natural', or Rems 23a or 28a-f show ant, the Medical Ever a withmatter realised at	by Fu	1 Never Married 2 Marrie	d 1 ☐ Yes 2 If Yes, Give	2 📉 No	1	s 2 X No	Specify:	to rican, stc.)	Specify:	/hite, etc.
21215-0036 od within 72 hours aft gjene. er than "natural; or er than "wedfeal Ewith		3 X Widowed 4 ☐ Divorced 15. Decedent's	Year or Da		Doodosta	laval Ossus				WHITE
215-0 hin 72 ho 3n "natur Medical	Completed	(Specify only highest	grade completed)		Decedent's U (Give kind of life. DO NO	work done Tuse retired	ation during most of wo d)	rking	l6b. Kind of Busine	ss/Industry
212 d with giene.	mo	Elementary/Secondary (0-12)	College (1-	40r 5+)		IOMEMA			OWN	HOME
and 2 be filed ntal Hygia of other	Be	17. Father's Name (First, Middle, La	ist)					me (First, Middle, M		110/111
larylan 2 should be and Mental Is marked o	2	EDGAR THOMAS MO						E. MORGAN		
re, Maryland s 1 and 2 should be file Health and Mental Hy item 27 Is marked oth other traumatic event		19a. Informant's Name/Relationship						ural Route Number,		
f an 1 an 1 an 1 an 1 an 1		NORMA E. NELSON 20a. Method of Disposition	/ DAUGHTER	20b. Place of	Disposition //	Vame of		ORWNSVILI		
Baltimore, permit. Pages 1 at Department of Hea amportant: If item any injury or otha		1 ⊠ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		tate <i>cemeter</i>	r, crematory o	or other plac	1		0c. Location - City	
altir nit. P nartme ortan injur injur	1	21. Signature of Fund Service Lie		Mr. ZI			ss of Facility			O, MARYLAND
Balt permit. Depart Import	1	DIN VIII	Pau Pau	1 m. Dean	BAST	FUNER	AL HOME		l nationa co, Maryl	
		23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that can	used the death. Do n	ot enter the m	node of dyin	g, such as cardiac	or respiratory arre	st,	Approximate
Physician		Immediate Cause (Final disease or condition		Preux	a and	a				Interval Between Onset and Death
/Medical Examiner		resulting in death)	Due to (o	r as a consequence of	f):	1	, 0	0		sweez 3
± Adminer	_	Sequentially list conditions,	b	Conges	true	nec	an fa	uline.		2 monly
Nsit ted	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dug 10 (5	ras a consequence of	1):	lan	20000			2 200 1001
), execu	Exar	that initiated events resulting in death) Last	c Due to (o	r as a copsequence o	1):	2016	NVVX			2 114114.
phine 68760, tilicate be executed gphysician and as the burial-transit	edicail		d	Rena	l	1235	uffic	uncy		monshe.
688 rtiffical ng phy as th	Medi	IS ESWALE.								
Box 6 death certiff	an/l	IF FEMALE: 23b. Was decedent pregnant		ome of pregnancy th 2 Tetal death	3 □Ectopia	pregnancy			23d. Date of c	delivery
19 0. Be dear the bed for	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnai 9□Unknov	nt at time of death	5 🗆 Other				Month	Day Year
P. C. J. Set and J. C. J. G. G. G. G. G. G. G. G. G. G. G. G. G.	Ph	Part II. Other significant condition	contributing to dea	th but not resultined in	the underlying	Cause cive	an in Part I	23e Did toba	LCCO USO CONTRIBUTO	to the cause of death?
<u> </u>	d by	6	Klusa	ration	and andonym	y causo give	211 (11 F Q1(1)	1 ☐ Yes	1	Probably 4 Unknown
الا م الا الا	lete	(200	0.1-	De	mes	9.0	24a. Was an		
Wital Revisions The law	Completed	-		cray	7 1/	mer	mg_	autopsy performe	prior t death	autopsy findings available o completion of cause of ?
an: Tal	a	25. Was case referred to medical	Jun	ten si	ント		26 Place of Dea	th (Check only one)		as 2□No
g : 5 - 7 - 7 - 7 - 7 - 7 - 7 - 7 - 7 - 7 -	To B	examiner? 1 ☐ Yes 2 XNo	Hospital:	patient 2 ER/Out	patient 3 🗆 I	DOA Othe		ome 5 Residen		pecify)
John of Jing Pt		27. Manner of Death 1 Statural 5 ☐ Pending	28a. ate of (Month,		me of ury	28c. Injury Work	at	28d. Describe how	injury occurred	
Vision Vision Attanding r death. actor: Afte	cati	2 Accident investigat 3 Suicide 6 Could not	bo -		М	1 🗆 1	Yes 2□No			
or At or At or At Dirace in by	Certification;	4 Homicide determine	288. Place of	f Injury - At home, fari g, etc. <i>(Specify)</i>	m, street, fact	ory, office		28f. Location (Stre City or Town,	et and Number or State)	Rural Route Number,
spital ours cours filled	2	29a. Certifier Certifying	hysician: To the b	est of my knowledge,	doath goovern	od at the tim	o data and also			
Division o To the Hospital or Attending Ph Within 24 hours after death. To the Funeral Director: After th	edical	(Check only 2 Medical Ex	miner: On the bas and manne	is of examination and	or investigation	on, in my op	pinion, death occur	rred at the time, date	se(s) and manner e and place, and d	as stated. Le to the cause(s)
Division To the Hospital or Attant within 24 hours after death To the Funeral Diractor: completely filled in by the	Me	29b. Signature and title of certifi	-	~ 1	2	9c. License	number	290	I. Date signed (Mo	nth, Day, Year)
•				12			1949	96 J	une 7	, 2004
H-4		30. Name and address of person wh	o complete cause		ype, Print)	n 2-kn	BARA D	d Brons	1 . A.	10)/2/1
E comment of		31. Date filed (Month, Day, Year)	TAIIM	MD Z	03116	app	uvis es	1 /SVOYS	0000 19	1) 4/13
St. Regist	ate rar		2004	gistrar's Signature	South	,				

			1 10000 1	State of Maryland /	Department of Health and	Mental Hy	giene
			For State Registrar	State of Maryland /	Certificate of Death		Reg. No. 004 20293
			Decedent's Name (First, Middle, Last)	.1		2. Date of Dea	ath 3. Time of Death
	Physici /Medio		Barbara Ann	Hendrichso		Month	08 04 1835 PM
}	Examir		4a. Facility Name (If not institution, give s		4b. City, Town, or Location of Di		4c. County of Death
	F		5. Social Security Number 6. Sex	7. Age (In yrs. last bi		Irs. 8. Date of Birt	h 9. Birthplace (State or Foreign
ŀ	Funeral Director			M 2□F 56	Yrs. Months Days Hours N	Irs. 8. Date of Birt (Month, Da) May 16	, 1948 Maryland
	D		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tov	wo or Location		10d. Inside City Limits
	Maryla f sho	or					1 ☐ Yes 2 ☒ No
	r 28a-	Director	MD Washingto	n Hage	rstown 101. Zip Code		10g. Citizen of What Country?
	th with		10021 Melody Lane		21740		USA
	tems	Funeral	THE THE PARTY OF T	Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Portion of the Property of the Propert	(Specify Yes or No- lerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	irs afte	by F	1 ☐ Never Married 2 🕅 Married 3 ☐ Widowed 4 ☐ Divorced	1	1 ☐ Yes 2 X No Specify:		Specify: White
9-0	within 72 hours after death with the Maryland ene. then "naturel", or items 23s or 28s-f show he Madical Evertirer must be profified at		15. Decedent's Educ (Specify only highest grade	ation 16a	a. Decedent's Usual Occupation	working	16b. Kind of Business/Industry
21	d within 72 ho plene. r then "natu ine Madical	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done during most of life. DO NOT use retired)	WOINING	N D C'
121	77 75 1- 1-		17. Father's Name (First, Middle, Last)	+2 Se	cretary	Name (First, Middle.	Non Profit
lanc	be de la la la la la la la la la la la la la	To Be	Marvin J. Summwers			a L. Bloo	,
Maryland 21215-0036	de la la	-	19a. Informant's Name/Relationship (Typ		b. Mailing Address (Street and Number or		
	CENL		Ronald Hendrickson		0021 Melody Lane, F		·
Baltimore,	of of if i		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	SINOVALITORI STATE	of Disposition (Name of erry, crematory or other place)	Date	20c. Location · City or Town, State
Itim			 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 		the state of the s		Flintstone, MD Minnich Funeral Home
Ba	permit. Departr Importe any inji		115				gerstown, MD 21740
	1		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death. Do	not enter the mode of dying, such as card	liac or respiratory ar	Interval Between
	Pnysician		Immediate Cause (Final disease or condition	Bilateral	Subdural Hemi	e tomas	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence	of):	rtomas irct	
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence		irec	
	cuted	Examiner	that initiated events				
50,	be executed sician and burial-transit		resulting in death) Last	Due to (or as a consequence	of):		
68760,	ate hy:	dical	d				
Box (leath certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy			23d. Date of delivery
		sicla	in the past 12 months? 1 ☐ Yes 2 ♠No	1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	h 3 Ectopic pregnancy 5 Other (specify)		Month Day Year
P.0	that the de ed by the detached	Phy	9 ☐ Unknown Part II. Other significant conditions con		in the underhing cause arres in Best I	220 Did to	bbacco use contribute to the cause of death?
ds,	Se ug	d by	rattii. Other significant conditions con	tributing to death but not resulting	in the underlying cause given in Fatti.	1 🗆 Y	Au
Record	w require been si should b	Completed				24a. Was	an 24b. Were autopsy findings available
	The taw ate has page 2:	ошр				 autop perfor 1 ☐ Yes 	sy prior to completion of cause of
Vital		BeC	25. Was case referred to medical examiner?		26. Place of I	Death (Check only or	
of V	Physicien: this certific ral director,	2	1 Yes 2 No H				lence 6 Other (Specify)
	ing After une	tlon	27. Manner of Death 1 □Natural 5 □ Pending 2 Accident investigation	(Month, Day Year)	Time of 28c. Injury at Work? M 1 ☐ Yes 2 ☑ No	r. 11	low injury occurred
Division	after death, Director: After Jin by the fune	fica	3 Suicide 6 Could not be	28e. Place of Injury - At home, f	100	28f. Location (S	Street and Number or Rural Route Number,
Ö	P Pir C	Certification;	4 Homicide	building, etc. (Specify)	me	10021 M	clody lane lagerstown Mi
	To the Hospitel within 24 hours a To the Funerel I completely filled	edical	(Check only 2 Medical Examin	er: On the basis of examination a	ge, death occurred at the time, date and pl nd/or investigation, in my opinion, death o	ace, and due to the	cause(s) and manner as stated.
	To the within 2. To the complet	Med	29b. Signature and title of confifier	and marmer stated.	29c. License number		29d. Date signed (Month, Day, Year)
)	F 3 F 8		TOUR	A TO DA FOR	P 440880		06 09 2014
SH	か		30. Name and address of person who co	mpleted cause of death (nem 23a)	(Type, Print)		
9			Thomas J. Gilber	t III D.U. FAC	of 251 E. Antiet	am St. A	lagerstown, MD 21740
	Sta Regist		31. Date filed (Month, Jun Year) 0 2(32. Registrar's Signature	Speck		29d. Date signed (Month, Day, Year) 06 09 2004 Regerstown, MD 21740
			i		8 A		

	7		State of Maryland / Department of State of Maryland / Department of State Registrar Certificate o	Health and Mer	ntal Hygie	ne N2004	20291
			1. Decedent's Name (First, Middle, Last)	2.	Date of Death	Day Year	3. Time of Death
	Physicia /Medic		Charles W. Harris Jr.	J1		2004	1415 M
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town	n, or Location of Death		4c. County of Death	1
	Funeral Director		Anne Arundel Medical Center Annapo 5. Social Security Number 6. Sex 1×10^{-7} Age (In yrs. last birthday) If Under 1 Yes 1×10^{-7} Age (In yrs. last birthday) Months Day	ar If Under 24 Hrs. 8.	Date of Birth	ear) Cou	ndel nplace (State or Foreign unity) yland
			Usual Residence of Decedent				
	72 hours after death with the Maryland Insturel, or Hems 23e or 28e-1 show Jical Exarctiner, ust be rediffed at	_	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits 1 XYes 2 No
	8e-11	Director	Maryland Anne Arundel Annapolis				
	dith th	Dire	10e. Street and Number 10f. Zip Code	9	10g.	Citizen of What Co	untry?
	s 23s			21401	- V	USA	inna Indian
	ltem Item	Funeral	Armed Forces? If Yes, specify Co	of Hispanic Origin? (Specify Juban, Mexican, Puerto Ric	an, etc.)	14. Race - Amer Black, White	
36	l', or	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give 1964—67 Year or Dates: 1 ☐ Yes 2 ☑ N	No Specify:		Specify: B	lack
21215-0036	thou sture	ed	15. Decedent's Education 16a. Decedent's Usual Occ	cupation	166	b. Kind of Business/l	ndustry
715	d within 72 ho plane. r than "natur r s Madical	plet	(Specify only highest grade completed) (Give kind of work dor life, DO NDT use reti	ne during most of working rired)	9	St John	's College
212		Completed	12th 0 Technical T	rane Helpe	er	,c. oomi	s correge
b	be filed tal Hygi d other event, I	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (F	First, Middle, Maid	den Sumame)	
/lai		10	Charles W. Harris Sr.	Alfredi	ia Turn	ıer	
Maryland	and lamin		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Stre	et and Number or Rural R	Route Number, Ci	ty or Town, State, Z	ip Code)
	s 1 and 2 should f Health and Men Item 27 is marke other treumatic			cson Place			
Ore	0 0		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other particular in the company of the particular in the cemetery of the particular in	olace)		c. Location - City or T	lown, State
Ë			*4 Donation 5 Other (Specify) Bestgate Memor	, 0,0,0	04 An	napolis	, Md.
Baltimore,	permit. Pag Department Importent: I any Injury o		21. Signature of Funeral Service Licensee 22. Name and Add		Mankan	D 3	
	40244		Zavry A, Reese M66483 Wm. Ree 23a. Part. Enter the disease, or complications had caused the death. Do not enter the mode of the second street the second street the mode of the second street t	t St. Anna	mortua polis,	Md. 21	Approximate
			Shock, of heart failure. List only one cause on each line.				Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Melastata Newsmall cell	lung conce	w Sterge	-4	
	Examiner		Due to (or as a consequence of):	-			
		e_	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
	uted d ansit	Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events c.				
ć	te be executed ysician and ie burial-transit		resulting in death) Last Due to (or as a consequence of):				
68760,	2 2 0	cai	d				
89	(D) T ==	Physician/Med	IF FEMALE:				
Box	eath certific attending p I for use as	an/l	23b. Was decedent pregnant in the past 12 months?	ncy		23d. Date of delin	very Day Year
		sici	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown	/		· · · · · · · · · · · · · · · · · · ·	Du, 100.
P.0	that the		Part II. Other significant conditions contributing to death but not resulting in the underlying cause	niven in Part I	23e. Did tobaca	use contribute to	the cause of death?
Records,	Pe Jo	d by	, , , , , , , , , , , , , , , , ,	3	1 Mes		obably 4 Unknown
Ö	w requir been s should	Completed			24a. Was an	24b Ware ou	tenau findings available
360	has has	d H			autopsy	prior to c	topsy findings available completion of cause of
a			Of West and referred to the second se	20 Bl (D - 1) (1 ☐ Yes 2 🖼	No 1 □ Yes	2 No
Vital	S 8 9	o Be	25. Was case referred to me warminer? 1	26. Place of Death (C		e 6 Other (Spec	26/1
of	ding Phyen. h. After this funeral di	-			d. Describe how i		ny)
ion	Attending or death. ector: After by the fune	atio		Work? □Yes 2□No			
Division	or Attend after death Director: A	HIC	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	ce 28f	Location (Stree City or Town, S	et and Number or Ru	ral Route Number,
D	tel or A rs after el Direc ed in by	Certification:	Building oto. (eposity)				
	To the Hospitel within 24 hours a To the Funerel I completely filled	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the common one of the common of the co	e time, date and place, and ny opinion, death occurred	d due to the caus at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	within To th	Ž	29b. Signature and title-of centifier 29c. Lice	ense number	29d.	Date signed (Month	, Day, Year)
•		-	700	558297	(0/3/01	
		-	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	× 00	0	0-7 A	\ O
			31. Date filed (Month, Day, Year) 32. Agistrar's Signature	reduit Cen	er An	may 66,5 10	V
	Sta Registi		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Howard Young MO Anne Armadel M 31. Date filed (Month, Day, Year) JUN 1 0 2004 JUN 2004				

			1 10430	State of Marylan			lealth and N	•	ene	
		•	For State Registrar	State of Marylan	-	rtificate of			g. N2 0 0 4	20205
			Decedent's Name (First, Middle, L.	ast)		timouto or		2. Date of Deat	1	3. Time of Death
	Physicia		Daniel F.	Harrington				June	8 2004	7:30 P M
	/Medid Examin		4a. Facility Name (If not institution, gr			4b. City, Town, o	r Location of Death		4c. County of Dea	
			Anne Arundel	Medical Cente	er	Annapo			Anne Art	
	Funeral			Sex 7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec. 26	Year) 9. Bir	thplace (State or Foreign ountry)
ļ.	Director	-	516-32-3965 Usual Residence of Decedent	7() 115.			Dec.26	, 1933 Mor	itana
	land ow		10a. State 10b. County	10c. City	y, Town or Lo	cation				10d. Inside City Limits
	Man 9-f sh	to	MD Prince	George's	Bow	ie				1 GYes 2 □ No
	or 28e	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?
	hours after death with the Maryland turel', or Items 23a or 28e-f show al Examination must be motified at	ral	2707 Filbert	Lane		207			USA	
	er des tams	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puert	pecify Yes or No- p Rican, etc.)	14. Race - Ame Black, Whit	
30	rs afte	by F	1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 TNo If Yes, Give Year or Dates:		1 ☐ Yes 2 X No	Specify:		Specify: Wh	ite
3		edi	15. Decedent's l	Education	16a. Dece	dent's Usual Occup	pation		6b. Kind of Business	
9500-61212	within 72 ene. than "na	plet	(Specify only highest g	rade completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of word d)	king	-	Commerce
7	od wit	Completed		4`	Pro	ject Of			U.S. Go	vt.
Maryland	be filed Ital Hygi od othar event, I	Be (17. Father's Name (First, Middle, Las					ne (First, Middle, N	•	
<u>×</u>		은	John F. Harr					n O'Con		
<u>a</u>	12 sho n and 7 Ism. raum.		19a. Informant's Name/Relationship		1				City or Town, State,	
	1 and Health 8m 27 ther ti		Marjorie Harra 20a. Method of Disposition			Filber sition (Name of matory or other place			MD. 207	
و	Pages nent of int: If it iry or o		1 Burial 2 □ Cremation 3 '4 □ Donation 5 □ Other (Spec						Bowie, M	
Baltimore,	그 든 뿐 글		21. Signature of Funeral Service Up						eral Hom	
ä	Depar Impor any ir		PRIMA	Y- well					wie, MD.	
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	mplications that caused the death						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Cardiovas	cular	Accide	ent			Onset and Death 3 days
	/Medical		resulting in death)	Due to (or as a consequence						, , , , , , , , , , , , , , , , , , ,
	Examiner		Sequentially list conditions,	b						
	ed sit	lne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ	uence of):					
_	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	cDue to (or as a consequence)	uence of):					
9/	ysiciar ysiciar ie buri	calE		d						
9				V.						
ŏ	eath certific attending pl	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna		Ectopic pregnanc	v		23d. Date of de	
о. Б	deat he att	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of do		Other (specify)	,		Month	Day Year
л О	at the de d by the a etached	Physician/Med	9 ☐ Unknown Part II. Other significant conditions		ulting in the u	adorbijas asusa su	on in Bort I	23e Did tob	acco use contribute to	the cause of death?
ŝ	The law requires that the death certifica tte has been signed by the attending ph page 2 should be detached for use as it	l by	Part II. Other significant conditions	Contributing to death but not less	ultilig ill til o u	riderlying cause git	ventin Patti.		9.0	robably 4 Unknown
Records,	w require been si	etec						24a. Was ar		
ž	The law cate has page 2:	Completed						autops	prior to death?	utopsy findings available completion of cause of
Vita			25. Was case referred to medical				26 Place of Dea	1 ☐ Yes 2 th (Check only one		2 □ No
	Attending Physician: r death. sctor: Atter this certifics by the funeral director, y	o Be	examiner? 1 ☐ Yes 2 No	Hospital: 15 Appatient 2 -	ER/Outpatier	nt 3 DOA Ott	205		nce 6 Other (Spe	cify)
ס ר	ding Ph h. After thi funeral	n: T	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Inju	ry at	28d. Describe ho		
000	Attendir death. ctor: Af y the fu	atlc	€ Accident investigat	on		M 1	Yes 2 □No			
DIVISION	or Attendated of the or Attend	Certification;	3 Suicide 6 Could not 4 Homicide determine	28e. Place of Injury - At he building, etc. (Specify	ome, farm, <i>s</i> ti y)	reet, factory, office		28f. Location (Str City or Town	eet and Number or Ri , State)	ural Route Number,
	ospital or A hours after unarel Dira ly filled in by		29a, Certifier 1 Certifying	Physician: To the best of my kno	wledge deat	h accurace at the ti	me, date and place	and due to the ca	use(s) and manner as	estated
	To the Hospital or A thin 24 hours after Tr the Funerel Director completely filled in by	edical		aminer: On the basis of examina and manger stated.						
	To th Tr th comp	Me	29b. Signature and true of contifier			29c. Licens	se number	25	d. Date signed (Mont	h, Day, Year)
)	(6)		> la	6		1Jr	735,	779	6/7/20	10
0	2		30. Name and address of person wh	o completed cause of death (ken	1 23а) (Туре,	Print) And	1 l. 1 1/	no dicel	Certa	
Ø(19 '01	10	31. Date filed (Month, Day, Yeer)	32. Registrar's Signa	iture	- /// ()	2110		and C	
	Sta Regist		JUN 1 1 2004	Scene do Son	de					

			For State Registrar	State of Marylar				ealth a D <i>eath</i>	ind Me	ental Hy	giene	000		202	06
	Dhusisi		1. Decedent's Name (First, Middle, Last)							2. Date of De Month		W	Year	3. Time of	Death
	Physici /Medio		Dorothy	E. Hendr	icks				i	June	5,2°	004		7:25	РМ
	Examin	er	4a. Facility Name (If not institution, give s					Location of	f Death			. County o			
			National Luthe		to a blat do a		ockvi		A Hro	0.0	Montgomery				
	Funeral Director		5. Social Security Number 6. Sex 162-07-0196	7. Age (In yrs. M 2XF 93	Yrs.	Months		Hours	Min.	8. Date of Bir (Month, Da	ay, Year,	9. Birthplace (State or Foreign Country) 11 Maryland			
			Usual Residence of Decedent							Jan. I	5,1	911	mar	yrand	
	ylanc how		10a. State 10b. County		ty, Town or Lo								1	0d. Inside Ci	ity Limits
	a-fs	tor	Md. Monto	gomery	R	ockv	rille	2						† X □Yes	2 □ No
	or 28	Olre	10e. Street and Number			10f. Z	p Code				10g. Ci	tizen of W	hat Cour	ntry?	
	ath w	- E	9701- Veirs Dr.					20850				USA			
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show fra Madical Exemirer must ke natilised at	Funeral Director	The state of the s	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Dece If Yes, spe	edent of Hi ecify Cuba	spanic Orig n, Mexican,	jin? (Spec , Puerto R	cify Yes or No lican, etc.)	0-		- Americ , White,	an Indian, etc.	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1 🗆 Yes	2 No	Specify:				Specify:	Wł	nite	
21215-0036	2 hou	ed	15. Decedent's Educ	cation	16a. Dece						16b. K	and of Bus			
215	hin 7.	ple	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of w DO NOT i	ork done d use retired	luring most)	of working	9					
21	od wit	Completed	12		Pro	prie	tor				De	eli-	Gene	eral	Stor
2	be filed stat Hygi od other evant, I	Be	17. Father's Name (First, Middle, Last)	iogor	•					(First, Middle	, Maider	Sumame)		
yla	should I nd Meni n marke umatic	၉	Howard B. Pfl							th But					
Maryland	2 sh and lam		19a. Informant's Name/Relationship (Type Rev. Dr. Reichard			-				Route Numb				· ·	
	1 and Health	1	20a. Method of Disposition		Place of Dispo			Dr.	, RC	ockvi]		, IMO . ocation - 0			
וסנ	Pages nent of h nt: If ite		1 XBurial 2 ☐ Cremation 3 ☐ R	omoval from State	emetery, crer • Paul:	matory`or	other place								
Baltimore,	⊢ at ⊐		' 4 □ Donation 5 □ Other (Specify) 21. Signature of Fungral Service Li ense	,				s of Facility		2004	Per	msbi	arg,	Pa.	
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			23a. Part1. Enter the disease, or compleshock, or hear failure. List only of	cations that vused the deal	th. Do not ent	er the	1 9 ay 1	, sthe	Stoor	ratory	្រែនា	D(2	Approximat	10
	Constant of the Constant of th	8 11	Immediate Cause (Final	ne cause on sch line.) /	+				Interval Bet Onset and I	Death
	Pnysician /Medical		disease or condition resulting in death)	Due to (or as a consec		and	lac	- ac	عاما	16.			/	mount	RIE
	Examiner			history	of e	010	nan	, 0	nter	-4 dis	eas	2		year	S
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consec	uence of):				UW	RT 1				/	
	ocuted nd transi	Examiner	cause. Enter Underlying Cause Classes Finjury that initiated events	histor	40	te	mys	stix	tice.	RT	17	LUN	٠	year	J
, 0	sate be executed ohysician and the burial-transit		resulting in death) Last	Due to (or as a consec	quende of):								Ì	,	
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical		l,											
9 ×	that the death certific ed by the attending pi detached for use as t	Me	IF FEMALE:	3c. If yes, outcome of pregn	2004								- '-		
Вох	attend for us	lan	in the past 12 months?	1 Live birth 2 Feta 4 Pregnant at time of c	aldeath 3	Ectopic p	regnancy					23d. Date Mont		•	Year
Р. О	the de	yslc	1 ☐ Yes 2 ☐ Ho 9 ☐ Unknown	9□ Unknown	Jean JE	_ Other (S	pecity)								
مز	that I		Part II. Other significant conditions con	tributing to death but not res	sulting in the u	nderlying	cause give	n in Part I.		23e. Did t	obacco	use contrib	oute to th	e cause of d	leath?
Sp.	w requires to been signer should be	d by	End Stage al	nheiners o	lemen	tia				1 🗆 🖰	Yes 2	□No 3	Prob	ably 4.	Jnknown
<u></u>	w rec	lete	<i>f e</i>	J						24a. Was	an	24b. W	ere autor	osy findings	available
Re	The ta	Completed								autor perfo	psy ormed? 2 No	pri	or to cor ath?] Yes	npletion of ca	ause of
Division of Vital Records,	physician: The law or this certificate has baral director, page 2 si	O .	25. Was case referred to medical					26. Place	of Death (1 ☐ Yes (Check only o		1	1 103	2 140	
<u> </u>	Attending Physician: If death. actor: After this certifica by the funeral director, I	To B	examiner? 1 ☐ Yes 2 ☑No	lospital: 1 Inpatient 2	ER/Outpatier	nt 3□ D	OA Othe	Pr: 4. Nur	sing Hom	e 5□Resi	dence	6 Other	(Specify)	
0	ding Ph h. After th funeral		27. Manner of Death 1 √Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	f	28c. Injury Work	at	28	3d. Describe	how inju	ry occurre	d		
<u>Ö</u>	utending death. ctor: After y the funer	atle	2 Accident investigation			М	1 🗆 1	/es 2□N	lo						
ž	after death Diractor:	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Special		eet, facto	ry, office		28	3f. Location (City or To			or Rura	l Route Num	ber,
۵	urs at			<u> </u>					+						
	Hosp 24 hor Fune Fune	edical		sicien: To the best of my kno ner: On the basis of examina)
	To the Hospital or At within 24 hours after of To the Funeral Diract completely filled in by	Med	29b. Signature and title of pertition	and manner stated.		29	c. License	number			29d. Da	te signed	(Month, I	Day, Year)	
)	F 3 F 8		1 / Ms	mall v	20			612				_		004	
	(2)		30. Name and address of person who co				,			1	00,	W.	1-		
1	(3)		Dr. Samuel Ma	•			D.	ooku-	11.	с Бм	005	0			
	Sta	ite_	31. Date filed (Month, Day, Year)	2. Registrar's Sign	atmee		· - K	UUK V.	TTTE	, Ma . 2	UOD	U			
	Registi		JUN 1 0 2004	Harry K.	2004	2									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year Month ANN LEE HURLEY 1:20A M /Medical 2004 June 4a. Fecility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Somerford Assisted Living Frederick Frederick 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Months 1 □ M 2 □ F 443-10-3483 89 Director Mississippi Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location rthan "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits Directo 1 ☐ Yes 2 ☐ No Arlington Virginia Arlington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6008 North 28th Street 22207 United States Pages 1 and 2 should be filed within 72 hours after death Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ğ Specify: White 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Home Maker Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental 27 is markad or traumatic even Cleveland A. Anderson Emma Downing 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i 6008 North 28th Street, Arlington, Virginia 22207
lace of Disposition (Name of Date Date Doc. Location - City or Town, State Patricia H. Schlueter-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages I Department of H Important: If ite any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Moore Memorial Gardens June 12,2004 Arlington, Texas 4 □ Donation 5 □ Other (Specify) 21. Signature of Foreral Service Lice 22. Name and Address of Facility Robert J. Murphy Funeral Home, Inc. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical cardiovascular disease Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of) Box 68760, Completed by Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 ☐Ectopic pregnancy igned by the atte be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) o يم Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No of Vital 1 Yes 2√2 No Attending Physician: ours after death.

neral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 MOther (Specify) 1 ☐ Yes 2X No Medical Certification; To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No М 2 Accident 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or A within 24 hours after To the Funeral Direc completely filled in by 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and the of certifie 29c. License number 29d. Date signed (Month, Day, Year) 01010 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

31. Date filed (Month, Day, Year) JUN 0 9 2004

JOSEF

C. DVORAK,

1635 North GeorgeMason Drive, Arlington, Virginia 22205 32. Registrar's Signature

M.D.

Registrar

			1 - For Stata Registrar	tate of Maryla	•	artment of I rtificate of		, 0.	ene	20298
	Physic /Medi		1. Decedent's Name (First, Middle, Last) William	Н	Н	elme		2. Date of Death Month JUNE 12	Day 2004 Yea	3. Time of Death 2:30 P M
	Examir		4a. Facility Name (If not institution, give stree Rt 4 and Patuxen	· ·	Pkwy	4b. City, Town, SOLOM	or Location of Death		4c. County of De	
	Funeral Director		5. Social Security Number 6. Sex 1 56 01 7368 1 ₩ M		s. last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day,) Aug 1 19	(ear)	irthplace (State or Foreign Country) W York
	Maryland f show	or	Usual Residence of Decedent 10a. State 10b. County Maryland Calvert	10c. C	Solomo					10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	death with the Maryland ms 23s or 28a-f show	Funerai Director	10e. Street and Number 11510 Emmanuel Way	# 529		10f. Zip Code 206	88	100	g. Citizen of What (United	Country?
980	iges 1 and 2 should be filed within 72 hours after death with the Marylan nt of Health and Mentat Hygiene. If item 27 is marked other than "neturel", or Items 23s or 28a-f show or other treumatic event, If e Medical Examiner was be rustliked at	by	1 Never Married 2 Married	Mas Decedent Ever in Armed Forces? I □Xfes 2 □ No f Yes, Give Year or Dates:	4.5	Was Decedent of I If Yes, specify Cub	dispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh Specify: W	
Maryland 21215-0036	l within 72 ho iene. r than "netur II e Medical	Completed	15. Decedent's Educatic (Specify only highest grade co		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of work	ring 16	Pyscholo	,
land 2	uld be filed flentat Hygi rked other tic event, I	To Be Co	17. Father's Name (First, Middle, Last) Edward Helme	<u> </u>				e (First, Middle, Ma yn Metzle	iden Sumame)	31
	and 2 should the should be		19a. Informant's Name/Relationship (Type, Anne Marie Helme- W		19b. Mailir 11510	ng Address (Street Emmanue	and Number or Rur 1 Way # 5	al Route Number, C 29 Solomo	City or Town, State,	Zip Code) 688
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is eny injury or other tre <u>once</u> .		20a. Method of Disposition 1 ☐ Burial 2 ☐ ♣ remation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	val from State	cemetery, crer	sition (Name of matory or other pla itan Fun	June 16 eral serv	2004	c. Location - City o	r Town, State Virginia
Balt	permit. Pa Departmen Importent: eny injury		21. Signature of Funeral Service Licensee	cl		2. Name and Address 5 Broomes I	s. Rd. Port	ausch Fur Republic	neral Hom MD 20676	e PA
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one or immediate Cause (Final disease or condition resulting in death)	ons that caused the dealuse on each line. Due to (or as a conse	tryon	er the mode of dyin	ng, such as cardiac	or respiratory arrest		Approximate Interval Between Onset and Death
8760,	icate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause, Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last	Due to (or as a conse						
.O. Box 68	death certifi e attending id for use as	Physician/Medi	in the past 12 months?	fyes, outcome of pregr □ Live birth 2 □ Fet □ Pregnant at time of □ Unknown	al death 3	Ectopic pregnancy	1		23d. Date of de Month	blivery Day Year
Δ.	quires that I n signed by uld be deta	by	Part II. Other significant conditions contribu	iting to death but not re	sulting in the ur	nderlying cause giv	en in Part I.	23e. Did tobad	. /	to the cause of death?
Records,	The law requires that the rate has been signed by the page 2 should be detache	Completed						24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
Division of Vital	ding Physician: n. After this certific funeral director,	Certification: To Be C	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	tal: 1 Inpatient 2 Ba. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury 12:44	28c. Injur Wor	er: 4 🗆 Nursing Ho	me 5 Residence 28d. Describe how	e 6 X iOther (Spe	
Divi	= 00		4 Homicide determined	Be. Place of Injury - At I building, etc. (Spec	wsy		6	TYEPATUS	KENT PTPKW	y aliverwand
	To the Hospitel or A within 24 hours after To the Funeral Directompletely filled in by	Medical		n: To the best of my kn On the basis of examin and manner stated.	owledge, death ation and/or inv	vestigation, in my o	pinion, death occurr	ed at the time, date	and place, and du	e to the cause(s)
	To wit		29b. Signature and title of certifier Wourie The	Shell M	N	29c. Licens	C M E		Date signed (Mon IUNE 13,	
6	10+1			DROW			enn Stree	t, Baltin	ore, Mar	yland 21201
S	Sta Registr		31. Date filed (Month, Day, Year) JUN 1 6 2	32. Registry's Sign	arure	food				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2004 **Physician** Year June 8, 1:50 p Kathryn Harrison /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert County Nursing Center Prince Frederick Calvert 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 👽 F Director 213-56-8202 30,1916 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show other treumatic event, the Modical Examitter must be notified at 1 ☐ Yes 21 No Director Maryland Calvert Prince Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20678 U.S.A. 85 Hospital Road or Items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status e filed within 72 hours after de if Hygiene. other than "natural", or Item 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 😾 No δ 3 NWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) homemaker own home 10 Pages 1 and 2 should be filed vent of Health and Mental Hygie int: If item 27 Is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Isabelle Katherine Gott Howard Marvin Humphreys 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 59, White Plains, MD 20695 Lawrence T. Harrison, Jr., son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages
Department of H
Important: If ite
any injury or of 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Memorial Gardens 06/11/2004 Dunkirk, MD 21. Sign of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home P.A., Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear fail re. List only one cause on each line. Approximate Interval Between Oaset and Death Immediate Cause (Lin Physician Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause Cause (Disease or injury Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as co equence that initiated events resulting in death) Last Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ arkinson um 1 Yes 2 No 3 Probably 4 Unknown Completed 03 teo arthrotons 24b. Were autopsy findings available prior to completion of cause of death? autopsy Arterioscherotre Cardrovascular Disease performed certificate Division of Vital 1 Yes 2 No 2 X No the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death, 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 124 hours e 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certifier 29c. License number 0 29d. Date signed (Month, Day, Year) lemer M.D. D17245 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gerald P. Sterner, M.D. 19 Chesapeake Beach Rd. E., Owings, MD 20736 31. Date filed (Month, Day, Year)

JUN 1 0 2004

DHMH 17 Rev 1/2001

State

Registrar

Bear & Specker

32. Registra Signature

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 6 **Physician HERBERT** HAMBLIN 2004 8 9:35 PM /Medical 4a. Facility Name (If not institution, give street and number)
12530 Murray RD 4b. City, Town, or Location of Death 4c. County of Death Examiner Worcester Whaleyville 8. Date of Birth (Month, Day, Year) 6/28/1923 Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 1 X M 2 ☐ F 7. Age (In vrs. last birthday) **Funeral** Hours MD 215-16-3666 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County 7 is marked other than "natural", or items 23a or 28a-f show treumatic event, the Medical Examiner must be notified at Whaleyville 1 ☐ Yes 2 No Worcester Director MD 10e. Street and Number Murray RD 10f. Zip Code 10g. Citizen of What Country? 21872 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No ff Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ◯XNo Specify: 3 ☐ Widowed 4 ☐ Divorced WWII 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) Coltege (1-4or 5+) Electric Co. Serviceman permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg.
Important: If item 27 is marked other
eny injury or other treum..... 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mattie Murray Horace S. Hamblin ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12530 Murray RD Whaleyville, MD 21872 Ethel Hamblin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dale Cemetery 6/12/04 Whaleyville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
The Burbage Funeral Home
108 William St. Berlin, MD 21811 23a. Part1. Enter(the disease, or complications that caused the degth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) motortar **Physician** 5 4ND /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physicien: The law requires that the death certificate be executed for use as the burial-transit physicien and Due to (or as a consequence of): Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 XNo 3 Probably 4 Unknown 1 ☐ Yes page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2/2/No 1 Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 Medical Certification: To 2 ☐ EB/Outpatient 3□ DOA 28d. escribe how injury occurred 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death. To the Funerel Director: A investigation the 1 6 Could not be determined 3 ☐ Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide Illad Hospitel 1 Gertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of 29c. License number 20507 30. Name and address of person wind completed cause of death (Item 23a) (Type, Print) 24 3+1 Joseph A. Grasso, 314 Franklin St., Bldg. I, Suite 108, Berlin, Md. 21811 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 10 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) June **Physician** 1:05 10 2004 James G. Hunt /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Millenium Health & Rehab. Center Edgewater If Under 1 Year If Under 24 Hrs. 8. Date of Birth Sept. 23, 1908 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. 1**XX**M 2□ F Maryland 95 212-16-4874 Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County item 27 le marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at Annapolis Anne Arundel 1 X Yes 2 □ No Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21401 U.S.A. 631 Chase Avenue Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. tXXYes 2 ☐ No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates: 1941-45 1 ☐ Yes 2000No Specify Specify: 3XXWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Automotive Car Dealer 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Caroline D. Lee Robert M. Hunt ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 743 Appomattox Road Davidsonville, MD Linda Watkins/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition **XX**Burial 2 ☐ Cremation 3 ☐ Removat from State Hillcrest Mem. Gardens 6/15/2004 Annapolis, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Licensee 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition Cerepro Vascular days **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Cardio Vasculas thenosclenotic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month in the past 12 months? Day Year 5 Other (specify) signed by the a ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be subbi Gency 1 ☐ Yes 2 ☐ No 3 Probably 4 Onknown peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has e 2 autopsy performed? page ; this certificate 1 Yes 2 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 2 ER/Outpatient 3 DOA Director: After this in by the funeral of 28a. Date of Injury (Month, Day Year) 28b. Time of 27 Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Matural 5 Pending 1 TYes 2 TNo investigation 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6-10-2004 D 50653 unang. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GYAN C. SURPANA 5851 eale wich ton Decelo 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Yea **Physician** JUNE 5, LENA В. HARE 2004 11:32 A^M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4603 68 th PL LANDOVER HILLS PRINCE GEORGES CO If Under 1 Year If Under 24 Hrs. 5 Social Security Number 7. Age (In yrs. last birthday) 6 Sax 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 2 1 1 F Yrs 249-86-0517 55 Director 19 1948 South Carolina Usual Residence of Decedent the Maryland 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits 28e-f ehow treumatic event, the Medical Examiner must be notified at 1

Yes 2 □ No Directo Landover Hills Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ U.S.A. 20748 4603 68th Place items 23a Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. soft Health and Inserted other than "naturel", or tlems 23. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private 12th Produce Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pauline Abney T. C. Hare ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5705 Euclid Street Cheverly, Maryland 20785 Cynthia Byrd / Daughter other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ABurial 2 Cremation 3 Removal from State ŏ permit. Page Department of Importent: If any injury or QDC9. BRENTWOOD, MARYLAND * 4 ☐ Donation 5 ☐ Other (Specify) FORT LINCOLN CEMETERY 6/12/2004 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. Jenkins Funeral Home 7474 Landover Road Landover, Maryland 20785 OL/ 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CONT disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate causa. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed as the burial-tran Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Dav 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2□ No 24a. Was an autopsy performed? Yes 2□No Hospitel or Attending Physicien: filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 ther (Specify) 1X Yes 2 □ No Certification: To SCENE 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medicai To the within 2 29d. Date signed (Month, Day, Year) 29b. Signat and title of certifier 29c. License number OCME JUNE 6, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 M 111 Penn Street, Baltimore, Maryland 21201 Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 1 1 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** A^{M} 2004 3:58 June Charles W. Ingram /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Prince George's Southern Maryland Hospital Clinton 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Months Hours Min. 1XM 2□ F Yrs. 5, 80 Mar. North Carolina Director 245-22-7060 Usual Residence of Decedent 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 27 is marked other than "natural", or itams 23a or 28a-1 show traumatic event, the Neutical Experience must be multified at 1 □Xyes 2 □ No Washington DC Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20020-3302 United States 3127 Park Drive Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Mie, etc. African 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Completed by 3 ☑ Widowed 4 ☐ Divorced American 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) be filed within all Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Private 10th Construction 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be flit Department of Health and Mental Hy Important: If item 27 Is marked oth any injury or other traumatic event 2008. 17. Father's Name (First, Middle, Last) Ethel Pemberton Roy Ingram 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20020-3302 3127 Park Dr., S.E. Wash., DC Ecolia I. Avent - Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 😾 Burial 2 □ Cremation 3 □ Removal from State Harmony Memorial Park 6/15/2004 Landover, MD Donation 5 Other (Specify) Stewart Funeral Home 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4001 Benning Rd., N.E. Wash., DC 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Pnysician Staphylocollus Pheumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner or as a consequence of): Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examine the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Munknown una disease Completed 24b. Were autopsy findings available prior to completion of cause of death?

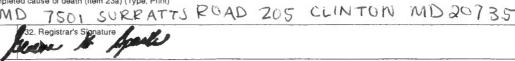
1 Yes 2 No 24a. Was an autopsy 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital or

within 24 hours at To the Funeral C completely filled it

DHMH 17 Rev 1/2001

RAHIMIAN MD 31. Date filed (Month, Day, Year) JUN 1 1 2004 Registrar

29a. Certifier (Check only one)



and manner stated.

19 ahunu au 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certific

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D0052999

29d. Date signed (Month, Day, Year)

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	Physicia		1. Decedent's Name (First, Middle,							2. Date of Di Month	Day	Yeer	3. Time of Opatri
	/Medic	al	Sheri Lynn Joh							May	13	2004	11:59 P M
	Examin	er	4a. Facility Name (If not institution,		mber)				ion of Death			ounty of Dea	ath
			Civista Medica 5. Social Security Number	1 Center	7. Age (In yrs.	last hirthday)	La P		der 24 Hrs.	8. Date of Bi		arles	rthplace (State or Foreign
	Funeral Director		219-15-5979	1 □ M 2 X F	24	Yrs.		ays Hou		Oct. 1	5, 19	79 Ma	aryland
	D .		Usual Residence of Decedent										
	show	_	10a. State 10b. County			ty, Town or Lo							10d. Inside City Limits 1 Tyes 27 No
	M M M	Director	Maryland St.Ma 10e. Street and Number	ry's	Me	chanic	10f. Zip Co	ado.			10a Citize	en of What C	
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	ns 23	Funeral	26800 Three No	12. Was Deci	edent Ever in U	J.S. 13.	Was Deceden	t of Hispanio	Origin? (Sp	ecify Yes or N		. Race - Am	nencan Indian,
ယ္	or Iter		1 ₩ Never Married 2 Marri	Armed For			f Yes, specify			Rican, etc.)		Black, Wh	
21215-0036	72 hours after death with the Maryland natural', or Items 23s or 28s-f show disal Esaminar must be multibud at	d by	3 Widowed 4 Divorced	Year or D	ates:		1 □ Yes 2 X	No Spe	спу:			Specify: Wh	nite
5-	natu ratica	iete	15. Decedent (Specify only highes			(Give	dent's Usual (kind of work of DO NOT use	tone during	most of work	ting	16b. Kind	d of Busines	s/Industry
12	within tene. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		h Care	,	stant		Hea1	th Car	re
d 2	Hygiv other	Be Co	17. Father's Name (First, Middle, L	.ast)		130000				e (First, Middle	, Maiden S	umame)	
ylan	2 should be fi and Mental H Is marked of raumatic ever	To B	Robert E. John	son				Ma	ary Pa	tricia	Gibbo	ns	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene 1 Health and Mental Hygiene 1 Health and Mental Hygiene 1 Health and Mental Hygiene 2 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar mast be notified at		19a. Informant's Name/Relationsh Mary P. Johnso		-					, Mecha			Zip Code) MD 20659
altimore,	of Health of Health item 27 r other tr	l j	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	2 Demoved from		Place of Dispo cemetery, crei	natory or other	r place)	1	Date			r Town, State
Ë	Pages ment of h ant: If ite ury or of		`4 □ Donation 5 □ Other (Sp		Mt.	Zion (Ch. Cen	etery	May 1	9, 2004	Mech	anics	ville, MD
Balt	permit. Page Department Important: It any injury o		21. Signature of Funeral Service L Edward Brins		per dvr MOOO!	52 3	Brinsli 80195 T	eId-Ed hree	chols Notch	Fun1. H Rd., Ch	lome, narlot	P.A. te Ha	11, MD 20622
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on e	caused the dear	th. Do not ent	er the mode o	f dying, sucl	n as cardiac	or respiratory	arrest,		Approximate Interval Between
	Pnysician	i ii	Immediate Cause (Final disease or condition	_a Acu	te Narc	otic A	nd Alco	hol I	ntoxio	cation A	And Co	саіпе	Onset and Death Use
	/Medical Examiner		resulting in death)	Due to	(or as a consec	quence of):							
		er	Sequentially list conditions,	b. Due to	or as a consec	uence of):			_				-
	uted d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	c									
0	be executed sician and burial-transit		resulting in death) Last		(or as a consec	quence of):							
8760,	ate he	Physician/Medicai		d									
9	leath certifica attending plant for use as I	/Mec	IF FEMALE:	23c If was our	tcome of pregn	ancy					-		-1:
Box	attend for us	cian	23b. Was decedent pregnant in the past 12 months?	1 Live	ointh 2 ☐ Feta nant at time of o	aldeath 3[Ectopic preg				23	Id. Date of de Month	Day Year
o.	that the died by the detached	ysic	1	9□ Unkn				.,,					
9	es that igned b	by PI	Part II. Other significant condition	ns contributing to d	leath but not res	sulting in the u	nderlying cau	se given in P	art I.	23e. Did	tobacco us	e contribute	to the cause of death?
rds	v require been sig should b	edt						· · · · · · · · · · · · · · · · ·		1 🗆	Yes 2	No 3□F	Probably 4 MUnknown
ecords,	e law re has be je 2 sho	Completed								24a. Was		24b. Were a	autopsy findings available completion of cause of
$\mathbf{\alpha}$	Th ate pag	Com									ormed? 2 ☐ No	death?	s 2 No
Vital	ysician: The is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othor		th (Check only			
of	S S	2	1 Yes 2 No 27. Manner of Death	1		ER/Outpatier 28b. Time o		A STATE OF THE PARTY OF THE PAR	Nursing H	ome 5 Res			ecify)
uo	ding h. After fune	tion	1 □Natural 5 □ Pendin	59 F9	of Injury th, Day Year) 2004	Found	P ^M	Injury at Work?	2 1 No	Unknow		occarred	
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Ö	in life	Certification:	4 Homicide	Oth	of Injury - At hing, etc. (Speci ner Res	idence				Mechani	csvil	1e, Mc	l
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	ledical (g Physicien: To the Examiner: On the b and mar									
	To the To the Comp	Me	29b. Signature and title of certifier				29c. l	icense numi	ber		29d. Date	signed (Mor	nth, Dey, Year)
•			> mes					O.C.M.	E.		May	14, 20	004
			30. Name and address of person	310, H	0	111		Street	, Bal	timore,	Mary	land 2	21201
	Sta Registi		31. Date filed (Month, Day, Year)		Registrar's Sign	ature	Spar	60	+				
			WALL WALL			-	-						

DHMH 17 Rev 1/2001

ORIGINAL

54.4
State Registrar
DHMH 16 Rev 6/95

				Pleas				Depa	rtment of	Health and	All Copies Mental Hy		jible.	
								Cer	tificate of	Death		Reg. No.	IN.	20305
	Physici	an	1. Decedent's Name		75.	TZTNIC					2. Date of D Month	Day	Year	'3: Time of Death
	/Media		Mary Lyr									11, 200		12:45
	Examir	ner	4a Fecility Neme (If		-						or Location of Dea		ty of Deeth	
			Washingt 5. Social Security No.		nty Hosp 6. Sex		(In yrs. last b	inthdevi	If Under 1 Yea		erstown		hingt	
	Funeral Director		215-64-01	1	1 □ M 2 🛣 F	1 15	51	Yrs.	Months Days		in. (Month, D	аў, _{Үеег)} 11,1952	Cou	place (State or Foreign ntry) ry1and
-	*	١,	Usuel Residence of	Decedent							верс.	11,1772	, ria	Lyland
	nylan show		10a. Stete	10b. County		1	IOc. City, Tov	vn or Loc	eation					10d. Inside City Limits
	Ba-fa	cto	Maryland	Wasl	nington]	Hage	rstown					1 X Yes 2 □ No
	# 5 2 H	Directo	10e. Street end Num						10f. Zip Code			10g. Citizen o		ntry?
	23e		1010 Bri	nker D						L740		US		
	ter de	Funera	11. Marital Status 1 ☐ Never Marrie	od O Alexande	12. Was De Armed F	orces?		13. W	Yes, specify Cul	Hispenic Origin? ban, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)	o- 14. Ra Bi	ace - Ameri ack, White,	
Š	irs af	by F	3 ₩ Widowed	_	If Yes, G			1	□Yes 2⊠ No	Specify:		Spec	ify: w1	nite
5	2 hou			15. Decedent's	Education		16a	. Decede	ent's Usual Occu	pation		16b. Kind of	Business/In	dustry
-	두 6 2	ple	(Special Special	grede completed	(1-4or 5+)		(Give k	rind of work done O NOT use retir	during most of w	vorking				
7	ad will	Completed	12	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	4	(,		nu	rse			hosp	ital	
2	T off E	Be	17. Fether's Name (I	First, Middle, L	ast)					18. Mother's N	ame (First, Middle	e, Maiden Suma	me)	
7	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "nature!", or flems 23a or 28a-f show reumetic event, the Medical Examiner must be notified at	ဥ	Lynwood								ary Elle			
0	2 sh and is m	Ì	19a. Informant's Na				1				Ru ra l Route Numi			
	1 and Health om 27 ther tr	ŀ	Mary Ann 20a. Method of Dispe		one - co						race, Ge			
5	pemit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'naturel', eny injury or other traumatic event, the Modical Ex- once.		1 Burial 2 □	Cremation :	B □Removal from	n State			ition (Name of etory or other pla			20c. Location	- City or To	own, State
	it. Partime		4 ☐ Donation :	<u>```</u>			Rose		1 Cemete		6/16/04			, Maryland
ם ב	permit. Departr Imports eny inje		21. Signature of Tur	O a /	I NA	n		1	./		MINNICH			
			23a. Part1. Enter the	00		1/4	nue	سلالي			d., Hage		Ma. 2	
· .	Navojajan		shock, or heart	tailure. List o	nly one cause on	each line.	e deem. Do	not enter	r the mode or dy	ing, such as cardi	ac or respiratory a	arrest,	1	Approximate Interval Between Onset and Death
	hysician /Medical		Immediate Cause (F		1	1000		1	1	10 101	0.		0)	
Į	Examiner		disease or condition resulting in death)		a	1220	ne to (or as a	are	D 110	riavasi	ular co	agulope	Thy	
Ψ.		Je l			SCI	PSUS	10 (OI as a	consequ	erice oi).				/	
	ba axecuted iclan and bunal-transit	Examiner	Sequentially list con if eny, leading to imr	ditions,	b	Du	e to (or as a	consequ	ence of):					
Š	a axe	al EX	if eny, leading to immodule. Enter Under Cause (Disease or in	ivina 📕	Sta	Ahr	11000	ccu	5 Inf	ection			i	
	ohysic the b	edica	that initiated events resulting in death) La		C		e to (or as a							
<	ine law requires triat the death certificate is the has been signed by the attending physic page 2 should be detached for use as the b	Me			d									
3	attani for us	Physician/M												
	ed by the detached	ysi	Part II. Other signific	ant condition	contributing to c	death but n	not resulting i	n the und	derlying cause gi	ven in Part I.				the cause of death?
	as mat m igned by be detac	by Pt	walt	ple s	Wer051	\$. 1 🗆	Yee MONO	3 🗌 Prol	oably 4 🗌 Unknown
3	v requiras been sig should b	b b	-			1.	0				24a. Was	en eutopsy		ere eutopsy tindings
	s bee	Completed	Chron	ic pa	m sy	~410	n.u				perfe	ormed?	CO	ailable prior to mpletion of cause death?
	ata has	E									1□	Yes No]Yes 2□ No
			25. Was case referre	ed to medical						26. Place of De	eath (Check only			
	this ce	2	examiner? 1 ☐ Yes ��N	lo	Hospital:	Inpatient	2 □ ER/O	utpatient	3□ DOA Ot	hor:	Home 5□ Resi		her (Specif	y)
	Auenuing Proysectan: or death. ector: After this certific by the funeral director,		27. Menner of Death	5 Pending	28a. Date (Mor	of Injury oth, Dey Yo	ear) 28b.	Time of Injury	28c. Inju Wo	ry at rk?	28d. Describe	how injury occu	rred	
	or: A	cat	2 ☐ Accident 3 ☐ Suicide	investiga	tion				M 1	Yes 2 No				
	after d Direct in by	Certification:	4 ☐ Homicide	determin	28e. Plec build	e of Injury ling, etc. (S	 At home, fa Specify) 	arm, stree	t, factory, office		28f. Location (City or To	Street and Num wn, Stete)	ber or Rura	l Route Number,
	prel [29a. Certifier	A Completion	Division To the									
1	Fun Fun etely	edical	(Check only 2 one)	Medical Ex	aminer: On the b	e best of m pasis of exa ner stated	amination en	d/or inve	stigation, in my	me, date and place opinion, death occ	e, end due to the curred at the time,	cause(s) and m date and place,	anner as st and due to	ated. the cause(s)
40 0	of the rospital of Attending is within 24 hours after death. To the Funerel Director: After completely filled in by the funer		29b. Signature and ti	tle of certifier	1	o. stated			29c. Licen	se number		29d. Date signe	ed (Month, I	Day, Year)
) '	->=0		1-3	IR-	H				14	3940				
,	4,5	-	30. Name and addres	ss of person wh	no completed cau	se of death	h (Item 23e)	(Type, Pi	rint) A	, , ,		<u> </u>	, ~,	~(
r),		W.E.		era, m	Δ	74	-	Joithe	r- Ave	Hoge	rstown	- MX	04
	Stat	е	31. Date filed (Month	Hall of 5	ZUU4 32. F	Registrar's			,		d			
	Registra	ar				alin.	- B.	Son	a. U.					

			1 - For State Registrar	Stat	te of Maryl			of Health of Death			giene leg. N2 0 0 4	20306
			1. Decedent's Name (First, Mid	die, Last)						2. Date of Dea	ith	3. Time of Death
	Physici		MARVIN	Ρ.		JOH	NSON			Month JUNE	10 2004	
	/Medic Examir		4a. Facility Name (If not instituti		nd number)			wn, or Location	n of Death	OUND	4c. County of De	
	ZXXIIII		21103 SAN MAR	ROAD				BOONSBO	ORO		WASI	HINGTON_
T	Funeral	-	5. Social Security Number	6. Sex		yrs. last birthday,		Year If Unde	er 24 Hrs.	8. Date of Birth (Month, Day		Birthplace (State or Foreign Country)
	Director		232-34-5030	1 🛛 M 2	^{JF} 77	Yrs.	Months	Days Hours	Min.	0V.4,		EST VIRGINIA
	pu ,		Usual Residence of Decedent		100	City Town						
	aryla shov	_	10a. State 10b. Coun	ту	100.	City, Town or L	ocation					10d. Inside City Limits
	8a-f	Director		HINGTON				OONSBOR	0			1 ☐ Yes 21 No
	or 2	<u>=</u>	10e. Street and Number				10f. Zip C	ode		1	log. Citizen of What	Country?
	ath v	<u>a</u>	21103 SAN MAR					2171.				S.A.
	er de	Funeral	11. Marital Status	Am	Decedent Ever i ed Forces?	n U.S. 13.	Was Deceder If Yes, specify	nt of Hispanic O Cuban, Mexica	rigin? (Spec an, Puerto R	ify Yes or No- ican, etc.)	14. Race - A/ Black, W	merican Indian, hite, etc.
36	s aft	by F	1 ☐ Never Married 2 ☑ Ma 3 ☐ Widowed 4 ☐ Divorce	. If Ye	Yes 2 □ NoWO es, Give		1 ☐ Yes 25	₫ No Specify	y:		Specify:	
Ş	72 hours after death with the Maryland neturel', or Items 23a or 28a-f show Jical Examiner must be morified at			ent's Education	rorDates: WA	R II	dent's Usual (Counction			16h Kind at Dunia	WHITE
21215-0036	be filed within 72 hours after death with the Marylan ital Hygiene. Id other then "neturel", or Items 23a or 28a-f show event, It's Madical Examiner instituted at	Completed	(Specify only high	est grade compl		(Give	kind of work DO NOT use	don <i>e duri</i> na mo	ost of working	9	16b. Kind of Busines	ss/industry
5	within iene.	E	Elementary/Secondary (0-12)	Colle	ege (1-4or 5+) 2.			CSMAN			MICTEAD I	ENERGY CO.
	filed Hygid Sther ent,		17. Father's Name (First, Middle	, Last)			DICH!		her's Name (First, Middle, I	Maiden Sumame)	MERGI CO.
an	ould be Mental Markad o	To Be	HOWARD JOHNSON	J				FANI	NIE ED	ANCES I	KISSINGER	
<u></u>	2 should be and Menta Is marked sumatic ev	-	19a. Informant's Name/Relation		t)	19b. Maili	na Address (S				, City or Town, State	a Zin Code)
Maryland	alth ar 27 is r trau		RUTH A. JOHNSO	M/SPOUS	r F			IAR ROAI			MARYLANI	
ē,	s 1 and 2 should if Health and Mer item 27 is marks other traumatic		20a. Method of Disposition	117 01 000.		b. Place of Dispo	sition (Name	of	D, DOO		20c. Location - City	
Baltimore,	00-		1 ☐ Burial 2 X Cremation 4 ☐ Donation 5 ☐ Other			cemetery, cre			(122)	10001		
≣	nit.		21. Sign. ture of Futeral Servi	/		MITHSBU	RG CRE 2. Name and	MATORY Address of Facil				G,_MARYLAND
B	Dep Imp		Day M.		Paul M.			NERAL HO	OME '		d National ro, Maryla	
			23a. Part 1. Enter the disease,	or complications	that caused the d	leath. Do not en	er the mode of	of dying, such a				Approximate
	Physician		shock, or heart failure. List Immediate Cause (Final	st only one cause	e opreach line.			- 1	10.01			Interval Between Onset and Death
1	/Medical		disease or condition resulting in death)	a	ue to (or as a con:	sequence of:	n (c)	0	00	SY		Somethis
	Examiner				ao to (o. ao a oon.	004001100 017.						5
		er	Sequentially list conditions, if any, leading to immediate	b	ue to (or as a cons	sequence of):	 					
	uted d ansit	Examiner	Cause (Disease or injury that initiated events	1								1
oʻ	execting an and rial-tr	Exa	resulting in death) Last	C. Du	ue to (or as a con:	sequence of):						
8760,	death certificate be executed e attending physician and d for use as the buriat-transit	cai		d								
9	tificat g phy as th	Physician/Medical										
Вох	eath certific attending p	2	IF FEMALE: 23b. Was decedent pregnant		s, outcome of pre		7=				23d. Date of d	delivery
	deatle atte	Cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 🗆 1	Live birth 2 ☐ F Pregnant at time of]Ectopic preg] Other (s <i>pe</i> c				Month	Day Year
Ö	that the de ed by the detached	hys	9 🗆 Unknown	901	Unknown							
ď.	de de de	by P	Part II. Other significant condit	tions contributing	g to death but not	resulting in the u	nderlying cau:	se given in Part	L	23e. Did tob	acco use contribute	to the cause of death?
Ë	w requires been sign should be					-				1 □ Ye	s 2.⊡No 3.∏1	Probably 4 Unknown
S	law re as bee 2 sho	ompleted								24a. Was ar		autopsy findings available
Vital Records,	The la	E								autops	ned? death?	
ta	sician: certifica rector, p	e C	25. Was case referred to medic	al				26 Plac	e of Death (1 □ Yes 2 Check only one	2 □ MS 1 □ Ye	es 2 No
\leq	Physician: this certifical	O B	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	1 🗌 Inpatient 2	ER/Outpatier	t 3 DOA	Other		20.00	nce 6 Other (Sp	necify)
ı of	g Ph er th	i.	27. Mann of Death	28a. i	Date of Injury (Month, Day Year			Injury at Work?			w injury occurred	cony
<u>o</u>	Attending r death. ector: After by the funer	atlo	1 Natural 5 ☐ Pend 2 ☐ Accident inves	ing tigation	(Monni, Day Your) Injury	М	1 ☐ Yes 2 ☐]No			
Division	or Atte	li ji	3 Suicide 6 Could 4 Homicide deter	mined 286.	Place of Injury - A building, etc. (Spe	t home, farm, str	eet, factory, o	ffice	28	f. Location (Str City or Town		Rural Route Number,
Ö	s afte s afte et Dir ed in l	Certification;			bunding, oto. (Opt	Jony /			13	Only of Your	, Siale)	
	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the t		29a. Certifier 1 Certify (Check only 2 Medica	ing Physician: T	o the best of my	knowledge, deatl	occurred at I	he time, date a	nd place, an	d due to the ca	use(s) and manner a ate and place, and du	as stated.
	the H in 24 the F the F	Medical	une)	and	manner stated.		vestigation, in	my opinion, de	ain occurred	at the time, da	ate and place, and du	le to the cause(s)
	To the within 2. To the complet	Σ	29b. Signature and title of certifi	er	1/	-	29c. L	icense number	~ ~	29	d. Date signed (Mor	~
			Hidre	c 11 1	(/n/	6)	236	23	77	one 11	1 way
A.	175X1		30. Name and address of person			tem 23a) (Type,	Print)	1.0		1 **		
Ý	7		Frederic H.				Medica	ıı Campu	ıs Koa	a, Hage	erstown, M	ID 21/42
	Sta		31. Date filed (Month, Pan Yea	4 2004	32. Pagistrar's Si	gnature J.	ng How					
	Registr	ar			1 Therese	~. M						

			State of Maryland / Department of Hear Pagistrar 1- State Registrar Certificate of De		ental Hygier	2001	20307
İ	Physici /Medic		Decedent's Name (First, Middle, Last) JAMES CHRISTOPHER JAFFE		2. Date of Death Month C	Day Year	3. Time of Death 08:55 M
	Examir Funeral		Months Days H	Kimo	8. Date of Birth (Month, Day, Yee	4c. County of Death 9. Birth Cou	plece (State or Foreign
	Director		NONE 169 M 2 F Yrs. 15 15 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		MAY 20 2	004 Mary	yĺand
	he Maryla 28a-f shor cuilled at	Director	MD Charles Waldorf				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	ath with 1	ral Dir	10538 BEECH WOOD DRIVE 20601			U.S.A.	ntry?
5-0036	d within 72 hours after death with the Maryland Jene. r than "natural", or Iteme 23a or 28a-1 show The Medical Eparanger must be redified at	by Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Signary Status 13. Was Decedent of Hispar If Yes, specify Cuban, Month of	anic Origin? (Spe Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: BLAC	etc.
7-612	within 72 h ene. than "natu he Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 16a. Decedent's Usual Occupation (Give kind of work done durin life. DO NOT use retired)	n ng most of workin	16b.	Kind of Business/In	ndustry
and 21	be filed that Hyg ad other	Be	TANES		(First, Middle, Maide		
магу	s 1 and 2 should I Health and Mer Item 27 is marks other traumatic	To	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end I	Number or Rural	Route Number, City	or Town, State, Zip	20601
ıtımore, I	e = 5		JAMES EDWARD JAFFE/FATHER 10538 BEECH WOO 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Da	ate 20c.	Location - City or To	own, State
Baitin	permit. Par Departmen Important: any injury		'4 □ Donation 5 □ Other (Specify) Resurrection Ceme. 21. Signal re of Funeral Survice mensee 22. Name and Address of	Facility J.	B. JENKIN		HOME
N	**************************************		23a. Part 1. Enter the disease, or complications that eaused the death. Do not enter the mode of dying, su shock, or heart failure. List only one cause on each line.			MARILAND	Approximate Interval Between Onset and Death
/on/	Physician /Medical Examiner physicien and physicien and the privat-transit physicien and physicien and physicien are physicien physicien are physicien physician phy	Ical Examiner	Immediate Cause (Final disease or conditions resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Last	rhage	hage.		14 days 14 days 10 days
O. Box 68	death certific e attending p id for use as i	Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐ Other (specify)	-1-		23d. Date of delive Month	ery Day Year
cords, r	The law requires that the ate has been signed by th page 2 should be detache	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in	n Part I.		use contribute to the	ne cause of death?
ı Ç	n: The law re icate has bee r. page 2 sho	Completed			24a. Was an autopsy performed?	prior to co	psy findings available mpletion of cause of
OI VIIAI	y Physician: ar this certifica eral director, I	n; To Be	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		(Check only one) e 5 Residence dd. Describe how inju		y)
VISIOII	Attanding ar death. ector: After by the fune	Certification;	Natural 5 ☐ Pending investigation 3 ☐ Suicide 4 ☐ Homicide		Bf. Location (Street a		il Route Number,
5	the Hospital or hin 24 hours afte the Funeral Dir npletely filled in		29a. Certifier 1 🕱 Certifying Physicien: To the best of my knowledge death occurred at the time do	date and place, ar	City or Town, State	s) and manner as of	ated.
	To the H within 24 To the Fi complete	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinior and manner stated. 29b: Signature and title of certifier 29c. License num			ate signed (Month,	
Ċ,			30. Naine and address of pelson who completed cause of death (Item 23a) (Type, Print)	000	J	une 4	,2004
2	Sta	te	31. Date filed (Month, Day, Year) Q2. Registrar's Signature	none,	MD.	9198=	7
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			1 - For State Registrar	State of Maryla	•	artment of H			ene	1. 20200
	Physici	an	Decedent's Name (First, Middle, Last, MARY ANN JOHNS					2. Date of Death Month June	Day Ye	
1	/Medi Examir		4a. Fecility Name (If not institution, give MANOR CARE NURS)	street and number)		4b. City, Town, or LARG			4c. County of D	
	Funeral Director		207-04-0040	7. Age (In y.	rs. la <i>st birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		^{Yeer)} 1940 FI	Birthplace (State or Foreign Country) LORDIA
	he Maryland 8a-f show	Director	Usual Residence of Decedent		City, Town or Lo	ASHINGTON	1			10d. Inside City Limits 1X Yes 2 □ No
	h with t	al Dir	10e. Street and Number 1603 ROBIN COURT			10f. Zip Code 20744		10	g. Citizen of What U.S.A.	Country?
036	be filed within 72 hours after death with the Maryland lat Hygiene. d other than "natural", or Items 23a or 28a-1 show event, Ira Madical Exaciliar must be retified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	Was Decedent of His f Yes, specify Cubar 1 ☐ Yes 2 🛱 No	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - A Black, W Specify:	merican Indian, thite, etc. BLACK
21215-0036	d within 72 ho giene. er than "natur Ir e Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+) 2 yrs	(Give	dent's Usual Occupa kind of work done d DO NOT use retired) n Administ	uring most of wo	rking	6b. Kind of Busine	ss/Industry
ğ	2 should be filed within and Mental Hygiene. is marked other than aumatic event, It a Mi	To Be C	17. Father's Name (First, Middle, Last) WILLIAM GARY	SR.			18. Mother's Nar CARRIE	me (First, Middle, M WITHE	aiden Sumame) RSPOON	
, Mar	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic en <u>once.</u>		19a. Informant's Name/Relationship (Ty DENNIS E. JOHNSO	N/HUSBAND	1603 I	ROBIN COU		ural Route Number, IASHINGTON		
Baltimore,	Pages 1 ment of H tant: if ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Hernando	natory or other place D, FLORID	A 6/6	5/2004	oc. Location - City Hernando	, FL
Ball	Depart Depart import any in		21. Signature of Funeral Service Licens	hall	74	474 Lando	ver Rd.	.B. Jenki Landover	MD 2078	
	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions of any, leading to immediate cause. Exter Indexty	Cardiopul Due to (or as a cons End Stage	monary A equence of): Cardion	Arrest	, such as cardia	c or respiratory arre	st,	Approximate Interval Between Onset and Death
8760,	icate be executed physician and the burial-transit	dicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	equence of):					
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rds, P	sign d be		Part II. Other significant conditions cor	tributing to death but not r	esulting in the un	nderlying cause give	n in Part I.			to the cause of death? Probably 4 XUnknown
Division of Vital Record	The law ate has b page 2 s	Completed						24a. Was an autopsy perform	prior t ed? death	autopsy findings available o completion of cause of ? es 2 No
<u> </u>	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ※ No	lospital:	☐ ER/Outpatient	Other		ath <i>(Check only one)</i> Iome 5 \(\subseteq \text{Residen}		acifu)
sion o	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		27. Manner of Death 1 ANatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	28c. Injury Work M 1 \(\supers		28d. Describe how		Journey
Š O	ital or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm, stre cify)	eet, factory, office		28f. Location (Stre City or Town,		Rural Route Number,
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0	5 M 5 0	Σ	29b. Signature and title of certifier	Thiseel		29c. License D00357		290	June 8,	
_	(10)		30. Name and address of person who co				WSON, MA	ARYLAND	21117	
	Sta Registr		3V. Date filed (Month, Day, Year)	2. Registrar's Sig		•	-			

Physician Medical Examiner Physician Medical Examiner Donald Eugene Jenkins, Jr. Physician Medical Examiner Donald Eugene Jenkins, Jr. 15956 Prince Frederick Rd. 15956 Prince Frederick Rd. 15956 Prince Frederick Rd. 100-20-66-8798 1			For	State of Marylan				ental Hygie	ne	
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30 Name and address of person who completed cause of death (Item 23a) (Type Print)	Hosp 4 hou Fune ely fil	Ca	(Check only 2 Medical Examin	er: On the basis of examina	wiedge, death	occurred at the tirvestigation, in my o	ne, date and place, a pinion, death occurre	nd due to the cause d at the time, date a	n(s) and manner as and place, and due	stated. to the cause(s)
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State 31. Date filed (Month, Day, Year) 32. Registrar's Signature 33. Name and accress or person with completed cause of death (Item 23a) (Type, Print) ARNEL CACTRENCE 12613 ON LINE CENTER (TR 100) WALKORF, MD 20632 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	20.		20 Name and addition of		222\ /T =:		110	,	11-1104	
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Amend item #23a, Ib; and 23a, II per physician Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 6/18/04, cs Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 2004 Savannaha Elizabeth Joseph May 30, 9:30 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 107 Roanoke Ave., Apt 1-B Loch Lynn Garrett 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 1 ☐ M 2 🖾 F Yrs. 2 216-63-5711 Director 18. Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Show r than "natural", or items 23a or 28e-f shov the Medical Examinational be notified at 1⊠Yes 2□No Director MDGarrett Loch Lynn 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 107 Roanoke Ave., Apt 1-B 21550 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status filed within 72 hours after 1 X Never Married 2 Married 1 ☐ Yes 2 ☒ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: Š 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: if item 27 is marked other th any injury or other treumatic event, Ithe once. Infant 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) unk Be Crystal. Marie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Crystal M. Hauser/Mother 107 Roanoke Ave., Apt 1-B, Loch Lynn, Md. 21550 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 □ Donation 5 □ Other (Specify) 6/2/2004 Oakland, Maryland Sanders Cemetery 22. Name and Address of Facility Stewart Funeral Home 21. Signature of Funeral Service Licenses 32 S. Second St., Oakland, Md. 21550 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Kessiraton /Medical Due to (or as a consequence of) Examiner SPINOMUSCULAR ATROPHY Sequentially list conditions, if any, leading to indirectiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to (or as a consequence or): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physiclan/Medlcai IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?
1 Yes 2 No Month Year 5 Other (specify) signed by the at d be detached for 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has birector, page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 esidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; 1 ☑ Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No death. 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \(\text{Homicide} \) ä within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

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32 Registrar's Signature

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1760,	ysician and he burial-transit	Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq Due to (or as a conseq Due to (or as a conseq	uence of):							
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Baltir	permit. P Departme Importan any injur.		21. Signature of Funeral Service License	//n	22	Name and A	ddress of Fac	olity John	n M. T	aylor	Fune	ral Home MD 21401
Baltimore, M	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deparament of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or liems 23a or 28a-f show any injury or other traumatic event, the Modical Examiner: unit be notified at once.		Ann Keller/wife 20a. Method of Disposition 1 Burial 2 XCremation 3 B. 4 Donation 5 Other (Specify)	emoval from State	Place of Disposemetery, cren	Place of Disposition (Name of emetery, crematory or other place) Ltimore Crematory			Date 20c.		s, MD 21401 Location - City or Town, State Ltimore, MD	
arylan		To Be	Howard L.B. Keller 19a. Informant's Name/Relationship (Type			g Address (St	reet and Nun	nber or Rura		ber, City o		
CA :	filed withi Hygiene. other than	e Comp	Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	College (1-4or 5+) 4	Stru	ctural			(First, Middl		ngineering	
21215-0036	n 72 hours "natural", cuical Ex	Completed by	3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade)	Year or Dates: WOY10 cation a completed)	16a. Deced	ent's Usual O kind of work d	ccupation one during m	ost of workii	ng		nd of Busine	
9	within 72 hours after death with the Maryland ene. Than "natural" or tlems 23e or 28e-f show he Moulcal Examiner I and be recified at	/ Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☒ Married	12. Was Decedent Ever in U. Armed Forces? 1 XYes 2 ☐ No If Yes Give	.S. 13. V	Vas Decedent Yes, specify □ Yes 2	of Hispanic (Cuban, Mexic		cify Yes or N Rican, etc.)			merican Indian, /hite, etc. White
:	with the	Direct	10e. Street and Number 2554 North Haven C	Cove		10f. Zip Co	_{de} 214	.01		10g. Citi	zen of What	Country?
	Maryland f show	, o	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Ar		y, Town or Lo		Annapo	lis				10d. Inside City Limits 1 ☐ Yes 2 ∑No
	Funeral Director		2.20-10-2440	7. Age (In yrs. 82	last birthday) Yrs.	If Under 1 Y Months Da	ear If Und ays Hours	er 24 Hrs. s Min.	8. Date of B (Month, D Aug.	irth 9ay, Year) 9 , 1 9	9. 21 Ma	Birthplace (State or Foreign Country) aryland
1833	Examin		4a. Facility Name (If not institution, give s 2554 North Haven			4b. City, Tow	m, or Locatio Annapo				nne A	_{rundel}
**************************************	Physici /Medic	~ ~	Howard L.	Keller					Month 56	Day 07	2 00	
			Registrar 1. Decedent's Name (First, Middle, Last)	State of Marylan 5 per FA,G83	_				2. Date of D		-411	3 Time of Death

			1 - For State Registrar	State of Marylan	-	artment of H		Re	g. No. 2	20312	
	Physic /Medi Exami	cal	Decedent's Name (First, Middle, Last ALBERTA LENNON ALBERTA LENNON ALBERTA LENNON A. Fecility Name (If not institution, give)	LONG		4b. City, Town, o	r Location of De	2. Date of Death Month JUNE	Day Yea 02, 20(04 8:30A M	
	Funeral		806 CARRINGTON 5. Social Security Number 6. Sec. Sec. Sec. Sec. Sec. Sec. Sec. Sec	AVENUE x 7. Age (In yrs. I	.,		EAT PLE	ASANT s. 8. Date of Birth (Month, Day,	PRING	CE GEORGES irthplace (State or Foreign	
	Director Mount		243 50 7596 Usuel Residence of Decedent 10a. State 10b. County	/1	Yrs.			FEB. 01,	1933 NO	ORTH CAROLINA 10d. Inside City Limits	
	with the Ma la or 28e-f s	Director	MARYLAND PRINCE (10e. Street and Number 806 CARRINGTON AV		EAT PLI	10f. Zip Code	207/2			XXYes 2 No	
030	72 hours after deeth with the Maryland natural; or Items 23a or 28e-f show digal Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 XXarried 3 Widowed 4 Divorced	12. Was Decedent Ever in U.: Armed Forces? 1 ☐ Yes ※ ※ No If Yes, Give Year or Dates:			20742 ispanic Origin? (in, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	UNITED ST 14. Rece - An Bleck, Wr Specify: B	nerican Indian,	
7	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If term 27 is marked other than "natural; or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+) 2YRS •	(Give life. L	lent's Usual Occup kind of work done of DO NOT use retired	during most of we	orking	6b. Kind of Busines	· · · · · · · · · · · · · · · · · · ·	
		To Be Co	17. Father's Name (First, Middle, Last) SHELTON LENNON				18. Mother's Na	ome (First, Middle, Ma OORE SHIPM	AN		
			19a. Informant's Name/Relationship (Ty COLONEL P. LONG, S 20a. Method of Disposition	SR. / HUSBAND	806 C	CARRINGTO	N AVE.	_	ASANT, MD Doc. Location - City o	20742	
			Y Burial 2 □ Cremation 3 □ F '4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	WAS	HINGTO	N NAT. CI	EM. 08-	JUN-2004	SUITLAN	D, MD	
F	Physician /Medical		23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) a. Gastric Mass Cancer, Undiagnosed								
蒙	ate be executed nysicien and he burial-transit	dical Examiner	Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to conse	rv Hea ence of):	rt Diseas	se				
	inal the death certific ed by the attending pl detached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 2 2 No 9 □ Unknown	3c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de	déath 3 🗌		23d. Date of de Month	olivery Day Year			
	been signed by	by	Part II. Other significant conditions con	tributing to death but not resul	lting in the un	derlying cause give	n in Part I.			o the cause of death?	
		e Completed	25. Was case referred to medical					24a. Was an autopsy performe 1 ☐ Yes 2€	prior to	utopsy findings available completion of cause of	
Division of vital	death. tor: After th	ertification: To Be	Axaminer? XX Yes 2 No H 27. Manner of Death XX Naturel 5 Pending investigation 3 Suicide 6 Could not be	ospital: 1 Inpatient 2 E 28a. Date of Injury (Month, Day Year) 2 28e. Place of Injury At hon	28b. Time of Injury	28c. Injury Work M 1 [] Y	r: 4 🗍 Nursing F	ath (Check only one) Home XX Residence 28d. Describe how	injury occurred		
opping or	ours afte	OF	4 Homicide determined 29a. Certifier XXX Certifying Phys (Check only) 2 Medical Examir	ician: To the best of my know	ledge death	occurred at the tim	e, date and place	28f. Location (Stree City or Town, S	State)	- Alabad	
7	within 24 h	Medical	29b. Signature and title of pertifier. 30. Name and address of person who co	and manner stated.	w	29c. License	inion, death occi	date	Date signed (Mont	to the cause(s)	
	Sta Registr		Dr. Gonzalez 31. Date filed (Month, Day, Year)	39. Registrar's Signatu		1221 Mer	cantile	Lane	Largo, MD		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rag. No. U U 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** June 4, 3:20 P Kenneth R. Langley 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince George's Southern Maryland Hospital Clinton If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 18, 19 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral 12** M 2 □ F Months Days Hours Min. 51 Yrs. 1953 Washington DC Director 578-70-8173 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "netural", or Itams 23e or 28e-f show the Wedical Examinat must be notified at No Yes 2 □ No **Funeral Director** Prince George's Temple Hills 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 20748 4610 Dara Drive United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status tXCXYes 2 □ No If Yes, Give Year or Dates:1970 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: Black Completed by 3 Widowed 4 Divorced 1972 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Electrican 12 Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be 1 Department of Health and Mental I Important: If Itam 27 is marked o any injury or other traumatic eva Leonard Langley Josephine Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) June Langley / Wife 4610 Dara Drive Temple Hills MD 20748 20b. Place of Disposition (Name of crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) Cheltenham Vetran's 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Important: I any injury o once. 4 ☐ Donation 5 ☐ Other (Specify) 6/14/2004 Chelteham, MD Cemeters. Name and Address of Facility
Alexander S. Pope Funeral Home 21. Signature of Funeral Service Licensee aloria avo 2617 Penn Ave SE Washington DC 20020 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) FAILURE **Physician** /Medical Due to (or as a consequence of): **Examiner** IDNEY FAILUNG Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner BLEED CLASTROINTEST NEAL resulting in death) Last Due to (or as a consequence of): ANEMIA Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ COAGULOPATHY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 TYes 1 Yes 2X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ▼No 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification; 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No Accident 6 Could not be 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

51 50 M OSIA, 6192 OXON HILL ROAD #500 OXON HILL MD

31. Date filed (Month, Day, Year)

JUN 0 9 2004

Secret & freely

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

29a. Certifier

29b. Signature and title of certifier

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day Physician Year June 4, 2004 12:35 P. M Forrest Lee Lynch /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Fort Washington Fort Washington Hospital If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday)
57 yrs Birthplace (State or Foreign
Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Min. 11⊠M 2□ F Yrs December 6,1946 Director Virginia <u>225–58–2585</u> Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itams 23a or 28e-f show the Medical Examinar rust be motified at Fort Washington MX Yes 2 □ No Maryland Prince George's Funeral Director 10g. Citizen of What Country? U.S.A. 10e. Street and Number 10f. Zip Code 20744 9703 Thorncrest Drive filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 MYes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Black Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Analyst Federal (Overment (Retired) Pages 1 and 2 should be filed very ment of Health and Mental Hygie tant: If itam 27 is marked other taury or other traumetic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Lynch Marrie Solamon ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Mizette E. Lynch (Wife) 9703 Thorncrest Drive FOrt Washington, Maryland 20744 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State Naryland Veterans Cemetery June 14, 2004 Cheltenham, Maryland MBurial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If eny injury or once. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ROLLINS FUNERAL HOME, INC. 4339 HINT PLACE, N.E. WASHINGTON, D.C. 20019 fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Arteriosclerotic Cardiovascular Disease Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of): Examiner physician and s the burial-transit or Attanding Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Diabetes Mellitus 1 Yes 2 No 3 Probably 4 Unknown Renal Failure Status Post 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Renal Transplant 2 No 1 Yes 2 **X**No 1 Tyes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No Certification: To 1 ☐ Inpatient 2XXER/Outpatient 3 ☐ DOA After thi funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred XXNatural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident hours after deat inaral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 Homicide To tha Hospitel o within 24 hours aft To tha Funaral Di within 24 hours a

To tha Funaral t

completely filled 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D18545 June 8, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pr. Wisotsky, M.D. 12070 Old Line Center #207 Waldorf, Maryland 20602 31. Date filed (Month, Day, Year) State JUN 0 9 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** LAWFENCE Tu /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, **Examiner** Howard Columbia Lorien Nursing & Rehab. Center 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** Days 1□M 2XF 23, 1920 Kentucky 83 Director 336-16-7914 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State ir than "natural", or itams 23a or 28a-f show the Medical Examinar must be notified at 1 X Yes 2 No Director Savage Maryland Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 8538 Storch Woods Drive, Apt. 1D 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 M Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Housewife 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) h and Mental h Unknown John Blackburn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) POA/ permit. Pagas 1 and 2 Department of Haalth a Important: If item 27 is any injury or other tree once. 8538 Storch Woods Drive, Apt. 1D, Savage, MD 20763 Theresa Ann Robertson - Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory | 6/8/2004 Alexandria, Virginia * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signature of Funeral Service Licensee lons 4739 Baltimore Ave., Hyattsville, MD 20731 ase 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) GEREBROVACOLAR ACCIDEN Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): use as the burial-transit and Due to (or as a consequence of): Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 🖾 No 4☐Pregnant at time of death 5 Other (specify) P.0. 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Tes 2 No 3 Probably 4 Munknown FIBRILLATION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' ANEMIA 1 ☐ Yes 2 ☐ No 1 Yes 2 No To the Hospital or Attending Physicien: within 24 hours after death.
To the Funaral Diractor: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Trursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No Certification: To 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 1 XNatural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check ont) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MA D0060520 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KHETERAN 201-109 RIVER NEEL RS. JALTIMORE, NO ZACK 31. Date filed (Month, Day, Year)
JUN 0 8 2004 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene admend item 1 = State #8 per fh, rm, 6/10/04 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Lynch 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SAL181419 HICOMICO TENINSULA Medick If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1□M 201 **Director** 218-30-1053 05/30/1930 Maryland Usual Residence of Decedent 05/03/1930 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 77 is marked other then "naturel", or Items 23e or 28a-f show traumatic event, I've Medical Even it at must be notified at 1 ☐ Yes 2 🛣 No Director MD Somerset Pocomoke City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1905 Dividing Creek Road 21851 Funeral <u>USA</u> 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify þ 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other then arry injury or other traumatic avent Elementary/Secondary (0-12) College (1-4or 5+) 12 Own Home none Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Dennis Jones Margaret Elizabeth Mandyohl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1905 Dividing Creek Road, Pecomoke City, No. 21851 Diana Webster/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ★Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Rock Creek Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 06-07-2004 Chance, Maryland Signature of Funeral Solvice Ligensee 22. Name and Address of Facility Hinman Funeral Home 8900 . M00295 11673 Somerset Ave., Princess Anne, MD 21853 Part1. Enter the disease, or complications that shock, or heart failure. List only one cause of caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Approximate Interval Between Onset and Death mmediate Cause (Final disease or condition resulting in death) Physician MIMINIE /Medical (or as a consequence of): **Examiner** EZIEN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner ng physician and as the burial-transit resulting in death) Last Due to (or as a consequence of): the attending physician Box 68760 Physiclan/Medical IF FEMALE esn 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4☐Pregnant at time of death detached 9 Unknown 9 🗌 Unknown been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Hunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe After this certificate 1 Yes 2 3 No 1 Yes 2 🗆 No or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA ō 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Division Injury 1 Matural 5 Pending s after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospitel within 24 hours a To the Funerel C Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check one) (29d. Date signed (Month, Day, Year) 29b. Signature 29c. License number 003226 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J.G. Santiano M.D., 100 8th Street, Pocomoke City, MD 21851 31. Date filed (Month, Day, Year) 32. Registras Signature State JUN 0 9 ZUU4 > bleve & sperle Registrar

		1 - For State Registrar	State of Marylar		artment of H rtificate of L			giene Beg. No? () (04 20317		
Physici	an	1. Decedent's Name (First, Middle, Last)				•	2. Date of De Month	Day	3. Time of Death		
/Medic	cal	Edelmira Rubio 4a. Facility Name (If not institution, give si		rkin	4b. City, Town, or	Location of D	June	4, 2004			
Examin	ier	217 Oak Avenue	goot and mambony			na Park			Anne Arundel		
Funeral	É	5. Social Security Number 6. Sex	M ONE		If Under 1 Year Months Days	If Under 24 I	Min. (Month, Da	th ly, Year)	Birthplace (State or Foreign Country)		
Director		Usual Residence of Decedent	87	Yrs.			April 24	, 1917	Colombia		
yiang how		10a. State 10b. County	10c. Ci	ity, Town or Le	ocation				10d. Inside City Limits		
Be-fel	Director	Maryland Anne Aru	nde1	Seve	rna Park	k 1 □Yes 2∑No					
E Or 2		10e. Street and Number 217 Oak Avenue			10f. Zip Code 2114	1. 6		10g. Citizen of			
within 72 nouts atter death with the maryland ene. Then "neturel", or items 23s or 28e-f ehow the Madical Ezaminer rivat to rodiffed at	Funerai		2. Was Decedent Ever in L	J.S. 13.			(Specify Yes or No		ce - American Indian,		
or Iter	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give			Vas Decedent of Hispanic Origin? (Specify Yes or No-Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ☑ Yes 2☐ No Specify: Colombian Specify: Hispanic					
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al Hyg d othe	Be	17. Father's Name (First, Middle, Last)					Name (First, Middle		me)		
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permit. Pages 1 and 2 should be tiled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Inpopurment of Health and Mental Hygiene. Inpopurment if time 27 is marked other then "neturel", or Items 28c or 28e-f ehow any injury or other treumetic event, the Martical Examinat relationship at QDCs.		21. Signature of Tuneral Service License	•		2. Name and Addres		Gasch's F	uneral :	Home, P.A.		
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ie dea the att	/sici	in the past 12 months? 1 ☐ Yes 2 █No 9 ☐ Unknown	4☐Pregnant at time of e		Other (specify)			MIC	onth Day Year		
The law requires that the de tie has been signed by the a page 2 should be detached f		Part II. Other significant conditions cont	tributing to death but not re	sulting in the u	inderlying cause give	en in Part I.	23e. Did t	obacco use con	tribute to the cause of death?		
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		30. Name and address of person who con		m 23a) (Type			inner		1		
1775			d Road Sui	te 200		Burnie		1061			
Sta Regist		JUN 0 8 2004	32. Registrar's Sign	eruna							

■ Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		1 - For State Registrar	State of Maryla		Certificate of			Reg. N	200) 4	2031				
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Examin		4a. Facility Name (If not institution, give				or Location of Death			c. County		Year 3. Time of De 9:42 a of Death nester 9. Birthplace (State or For Country) Maryland 10d. Inside City L 12 Yes 20 hat Country? - American Indian, white, etc. White interest Indian, white, etc. White interest Indian, white, etc. White interest Indian, white, etc. White interest Indian, white, etc. White interest Indian, white, etc. Approximate Interval Between Onset and Death of Country in Day Year and Death of Country in Day Year and Death of Country in Day Year Indian State (Specify) If or Rural Route Number, or Rural Route Number, and due to the cause(s)				
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Ked ic ev	To B	Charles Goldsboro	ough Meredith	, Sr.		Etta T	`a11								
Importent: If item 27 is marked other than "natural", or items 23a or 28e-1 show eny injury or other treumatic event, the Madical Examinat must be notified at once.	-	19a. Informant's Name/Relationship (7 Allan L. Meredith	ype, Print)	19b. M	lailing Address <i>(Stre</i> e Shawnee Ro					State, Zip	Code)				
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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) June 15, 2004 **Physician** Frank Newcomer McKee 1:25 a M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Homewood Williamsport Washington 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year)

Dec. 10, 1923 Birthplace (State or Foreign Country)
 Maryland 7. Age (In yrs. last birthday) 6 Sex **Funeral** 1 X M 2 ☐ F Yrs. 216-14-6242 80 Director Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location "natural", or flems 23a or 28a-f ehow 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland | Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11029 Lincoln Avenue 21740 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. within 72 hours after 1 Never Married 2X Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: þ Specify: white 3 ☐ Widowed 4 ☐ Divorced 2 shourd be and Mental Hygiene.
7 Is marked other than "natural" Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) estimator 12 contracting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be innent of Health and Mental I Allen McKee Lula Newcomer ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert McKee - son 10819 Oak Valley Dr., Hagerstown, Md. 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of Important: If it Burial 2 □ Cremation 3 □ Removal from State 6/18/04 * 4 ☐ Donation 5 ☐ Other (Specify) Beaver Creek Cem. Hagerstown, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 lume 23a. Part1. Enter the disease, or x mplical insight caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) TO SCLOOK **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to fur as a consequence of Examiner Due to (or as a consequence of) The law requires that the death certificate be Be Completed by Physician/Medical 950 23c. If yes, outcome of pregnancy t ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2. No 3 Probably 4 Unknown GKILGOL 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an filled in by the funeral director, page 2 autopsy performed? Yes 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Yes 2 No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death Director: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a **Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 To the I 29b. Signature and title of ce 29d. Date signed (Month, Dey, Year) ္ဌ Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

Maryland 21215-0036

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Box 68760,

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Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend#20a.b.c.PerFH PGC 6-17-04cr State of Maryland / Department of Health and Mental Hygiene For State 6-14-04 Registrar Amend# 1.PerPhys.PGC cr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** MCOUFFY, MCDUFFY JUNE 7: 20 PM 2004 WILLIAM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NIA UNIVERSITY OF MARYLAND MEDICAL CENTER BALTIMORE If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days 192 M 2 F Months Hours 22 Yrs MARCH 21 1982 Washington, D.C Director 578-06-8603 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits wods i r than "natural", or items 23a or 28a-f shor the Madical Examiner must be notified at D.C. 1X Yes 2 No Director Washington 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 20010 U.S.A. 1489 Newton Street, N.W. #44 Funerai 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Sears Department Store Elementary/Secondary (0-12) Cottege (1-4or 5+) Stock Assistant other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked ofth any jury or other traumatic event, pixe. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) William James Hawthorne Angela D. McDuffy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1489 Newton Street, N.W. #44

Washington, D.C. 20010

20b. Place of Disposition (Name of cometery, crematory or other place)
Riverdale Park Crem.
Mt. Zion Gemetery

Mt. Zion Gemetery

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1489 Newton Street, N.W. #44

20c. Location - City or Town, State, Zip Code)

Riverdale, Md.

Baltimore, Mary 19a, Informant's Name/Relationship (Type, Print) Angela D. McDuffy/Mother Baltimore. 20a. Method of Disposition 20c. Location - City or Town, State TABurial 2 Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22 Name and Address of Facility W. H. Facon Funeral Home, Inc. 21. Signature of Funeral Service Licensee 3447 14th St., N.W. Wash., D.C. 20010 Sacon Wanda 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** AORTIC DISSECTION WEEKS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Ö 9 Unknown 9 Unknown of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 2)X No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2/1/No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Division Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a

To the Funeral D

completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number #14549 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MO AU4176435K14549 JUNE 3, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AHMET 22 South Green St. Baltimore Md. 21201 KILIC 31. Date filed (Month, Day, Year) JUN 1 1 2004 State Registrar

the Maryland

death

72 hours after

filed within 7 Hygiene.

12 should be filed w h and Mental Hygier 7 is marked other th

s 1 and 2 s of Health an item 27 is

Baltimore. Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records,

item 27 is marked other than "neturel", or items 23a or 28e-1 show other treumatic event. The Modical Examinar must be notified at

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day}2004 Year **Physician** June 5, MALIK MCCOY 1232 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery General Hospital Olney Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 12 23 1987 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**☆**M 2□F 373-11-6275 Yrs. Director 16 North Carolina Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits Yes 2 No Director Silver Spring MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4047 Chesterwood Drive 20906 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 25 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ Black Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private 10th Student 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Stephen O. McCoy Stephanie G. Gaddy ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4047 Chesterwood Drive Silver Spring, Maryland 20906 Stephen O. McCoy/Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Importent: If itel
any injury or oth 1

Burial 2 □ Cremation 3 □ Removal from State 6/11/2004 * 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Silver Spring, Maryland 22. Name and Address of Facility 21. Signature of Funeral Şervice Licensee J. B. Jenkins Funeral Home 7474 Landover Road Landover, Maryland 20785 0 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due b (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or, Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 DUnknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 1 Yes 2[] No 2 🗆 No

Physician /Medical Examiner

certificate be executed burial-transit physician use as the the á certificate has this After ! Certification;

Completed 2

25. Was case referred to medical 27. Manner of Death

examiner'

1 Natural

29a. Certifier

2 Accident

Suicide

(Check only one)

Homicide

XXYes 2 ☐ No

Hospitel or Attending after death. 24 hours a

Medical To the within 2 State Registrar

Hospital: 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 28b. Time of Fud 115 1 ☐ Yes 2 🗷 No

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred get orphypiet / an

26. Place of Death (Check only one)

1 6/4/04 Place of Injury At home, farm, street, factory, office building, etc. (Specify)

home 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 XMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Location (Street and Number or Rural Route Number, City or Town, State)

June 5, 2004

29b. Signature and title of certifier

5 Pending

investigation

6 Could not be determined

29c. License number O.C.M.E.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause, I death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

(HEDDORE MIKE 31. Date filed (Month, Day, Year) JUN 1 1 2004

2. Registrar's Signature

			State of Maryland / D	Department of Health and Mer	ntal Hygiene
			Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of Death	Page No. U J J J J J J Date of Death
	Physicia /Medic	al	LUCILLE VIRGINIA MCJIMPSE	EY U	une 3 2004 10:12 A M
	Examin	er	4a. Facility Name (If not institution, give street and number) DOCTOR S COMMUNITY HOSPITAL	4b. City, Town, or Location of Death LANHAM	4c. County of Death PRINCE GEORGE'S
pla	uneral Director		5. Social Security Number 577-24-0739 Usual Residence of Decedent	hday) If Under 1 Year If Under 24 Hrs. 8. Months Days Hours Min. At	Date of Birth (Month, Day, Year) 1919 9. Birthplace (State or Foreign Country) WASHINGTON, DC
1 1 Vajinja	ehow ed at	J.	10a. State 10b. County 10c. City, Town		10d. Inside City Limits 1X Yes 2 □ No
In the M	or 28e-f	Funeral Director	MD PRINCE GEORGE'S LAN 10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
leath w	ne 23a o	erai	7209 MARTINS COURT 11. Marital Status 12. Was Decedent Ever in U.S.	20706	U.S.A. y Yes or No- 14. Race - American Indian,
1215-0036 With the Maryland	it of neath and water riggers in the material, or fleme 23s, or 28e-f show or other treumstic event, it a Medical Examiner must be multiled at	þ	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☑ Yes 2 ☐ No 1 ☐ Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rican I ☐ Yes 2 XNo Specify:	Black, White, etc. Specify: BLACK
1215-0	ne. hen "natu e Medical	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
2 B	other th	Be Co	2yrs VA. 17. Father's Name (First, Middle, Last)	. ADMINISTRATIVE CLERK 18. Mother's Name (Fi	GOVERNMENT irst, Middle, Maiden Sumame)
2 5 2	narked o	ToE	RICHARD JOHNSON	LUCY LUMPK	
7 = 0	other treum			Mailing Address (Street and Number or Rural Ro 55 BRENISON DRIVE GAIT	oute Number, City or Town, State, Zip Code) HERSBURG, MARYLAND 20879
) b %	: If item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of I cemetery.	Disposition (Name of Date v, crematory or other place)	20c. Location - City or Town, State
Baltimor	Department of importent: If I any injury or one	Ì	4 □ Donation 5 □ Other (Specify) MARYLAT	ND NATIONAL 6/11/2 22. Name and Address of Facility J. B	. JENKINS FUNERAL HOME
n 88	8 2 2		23a. Part1. Enter the disease, of complications that caused the death. Do no		ANDOVER, MARYLAND 20785
	ysician fedical	and and a second	Immediate Cause (Final disease or condition resulting in death)	130	Interval Between 9nset and Death
Exc	hysician and the burial-transit	ical Ex	Due to it ras a consequence of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to it ras a consequence of the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the cause of the cau	η:	entia 7 yrs
P.O. Box 68760, nat the death certificate be ex	by the attending parached for use as I	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)	23d. Date of delivery Month Day Year
rds, P	been signed b should be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the Colombia Conditions contributing to death but not resulting in the Colombia Conditions contributing to death but not resulting in the Colombia Conditions contributing to death but not resulting in the Colombia Conditions contributing to death but not resulting in the Colombia Conditions contributing to death but not resulting in the Colombia Conditions contributing to death but not resulting in the Colombia Conditions contributing to death but not resulting in the Colombia Conditions contributing to death but not resulting in the Colombia Conditions contributing to death but not resulting in the Colombia Conditions contributing to death but not resulting in the Colombia Conditions contributing to death but not resulting in the Colombia Conditions contributing to death but not resulting the Colombia Conditions contributing to death but not resulting the Colombia Conditions contributing contributing contributing contributing contributing contributing contributing contributing contributing contributing contributing contributing contributing contributing contri	the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2-1 No 3 ☐ Probably 4 ☐ Unknown
Division of Vital Records, ior Attending Physician: The law requires the standards.	e has	Completed	to lairway cong.	estrien	24a. Was an autopsy autopsy performed? 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No
f Vita	is certificat director, pa	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ▼Inpatient 2 ☐ ER/Outp	26. Place of Death Chepatient 3 □ DOA Other: 4 □ Nursing Home	heck onl_one 5 ☐ Residence 6 ☐ Other (Specify)
on of	fter th		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) Injury	me of 28c. Injury at 28d. Work?	Describe how injury occurred
ivisio or Attendii	irector:	Certification:	2 Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No m, street, factory, office 28f.	Location (Street and Number or Rural Route Number, City or Town, State)
Hospitai	To the Funeral D	Medical Ce	29a. Certifier (Check only one) 20 Medical Examiner: On the basis of examination and/and manner stated	death occurred at the time, date and place, and of or investigation, in my opinion, death occurred a	due to the cause(s) and manner as stated. It the time, date and place, and due to the cause(s)
To the	To the		29b. Signature and atte of certifier	29c. License number 0 162 7-3 A	29d. Date signed (Month, Day, Year)
CAR	5/		30. Name and address of person who completed cause of death (Item 23a) (To	ype, Print) / 3 p / Burdo	war Rd Charrent
4	Sta		31. Date filed (Month, Day, Year) 2. Registrar's Signature	_	Mo Mo
	Registra	ar	JUN 0 9 2004 Bearing &	norte	

Simone Arvice Missouri Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04 - 03764State of Maryland / Department of Health and Mental Hygiene RPD 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** June 5, 1738 P M 2004 SIMONE ARVISE MISSOURI /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Fort Washington 8800 Oxon Hill Road Prince George's If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2XXF Months Days Hours Yrs. Director 578 15 7022 22 08, 1982 WASHINGTON, DC Usual Residence of Decedent the Maryland 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits Item 27 is marked other than "natural", or itams 23a or 28e-f show other traumatic event. The Madical Expression at received the modified at XXYes 2 No PRINCE GEORGES FORT WASHINGTON MARYLAND Direct 10e, Street and Number 10f, Zip Code 10g. Citizen of What Country? 9018 TAYLOR LANE 20744 UNITED STATES death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes Z Z No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. ould ba filed within 72 hours after Mental Hygiene. 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XX Specify: þ **BLACK** 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Ĭ+ MEDICAL STUDENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JEROME MISSOURI GERALDINE COLEMAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Item 27 9018 TAYLOR LANE FORT WASHINGTON, MD 20744 GERALDINE WILLIAMSON / MOTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If Ite any injury or ot once. XX Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) MT. OLIVET CEMETERY 12 JUN 2004 WASHINGTON, DC 21. Signature of Funeral Service L 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MARYLAND, INC. 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Enysician disease or condition resulting in death) /Medical Due to (or as a consquence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, [Oisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): attending physicien P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No ğ Month Year Day 4 Pregnant at time of death 5 Other (specify) ed by the a detached f Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Nnknown page 2 should Completed baen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has Yes 2 No 1 Yes 2 No Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1X Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6XXX ther (Specify) At Some 28d. Describe how injury occurred Date of Injury (Month, Day 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: which in when To the Hospital or Attending 1 Natural Injury 5 Pending after death. Director: A 15-10X 27 2 Accident investigation 6 Could not be determined 3 Suicide Place if Injury - At home, farm, reet, factory, office building, etc. (Specify) 28f. Location (Street and Num City or Town, State) 4 Homicide Price 416m within 24 hours a To the Funerel D

State Registrar

completely

cal

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

heoden

JUN 0 8 2004

THEODEREM. Ku 32. Registrar's Signature

30. Name and address of person who completed cause I death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurs, at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

June 6, 2004

111 Penn Street, Baltimore, Maryland 21201

			1 - For State Registrar	State	of Marylan		artment <i>rtificate</i>			Mental Hy	ygienę Reg. No.	21101.	20324
	Physici /Medi		Decedent's Name (First, Middle, And		More1					2. Date of D	eath Day	2004	3. Time of Death 7:45 PM
	Examir		4a. Facility Name (If not institution,				4b. City, To	own, or	Location of Dea			County of Death	
			Doctor's Comm			to a district of	1	Lank	nam If Under 24 Hi	·		rince Ge	
	Funeral Director		218-63-8794	S.Sex 1 □ M 2 X F	7. Age (In yrs. 76	last birthday) Yrs.		Days	Hours Mi		$\frac{irth}{ay}$, $\frac{1}{1}$	927 9. Birth	place (State or Foreign ntry) West
	D		Usual Residence of Decedent							ночешь	CI JU	, Hait	i, Indies
	irylan show	_	10a. State 10b. County		10c. Cit	y, Town or Lo	or Location 10d. Insi						10d. Inside City Limits
	8a-fs	cto		e George	s	Greenl							1X Yes 2 No
	death with the Maryland ms 23a or 28a-f show rmust be notified at	by Funeral Director	10e. Street and Number	1		000	10f. Zip C	10f. Zip Code 10g. Citizen of What Country					,
	leath	erai	11. Marital Status	7	Terrace; Apt. 302			207		Specify Ves or N		ti, West	
(0	r Iten	Fun	1 Never Married 2 Marrie	Armed F d 1 ☐ Yes	orces? 2 X No	i i				Specify Yes or Nerto Rican, etc.)	4	Black, White,	etc.
21215-0036	72 hours after natural; or Ite	b	3 Widowed 4 Divorced	If Yes, G Year or I	If Yes, Give			□No	Specify: Ha	aitian		Specify: B1	ack
5-0	72 h	Completed	15. Decedent's (Specify only highest	Education grade completed)	(Give	dent's Usual (kind of work	done d	luring most of w	orking	16b. Kir	nd of Business/In	dustry
121	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Manylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or liems 23a or 28a-1 show any injury or other traumatic event, the Medical Exercitive must be useful at once.	I du	Elementary/Secondary (0-12) 11th grade	College	(1-4or 5+)	life.	DO NOT use	retired,) -			D	
9		ပ္ပိ	17. Father's Name (First, Middle, La	ast)		В	omestic	- 1		ame (First, Middle		Domestic	3
an	ld be ental ked o	To Be		re1						e-Pierre			
Maryland	should be tand Mental H s marked of umatic ever	-	19a. Informant's Name/Relationship	p (Type, Print)		19b. Maili	ng Address (S	Street a		Rural Route Numb			Code) 20770
Ξ	and 2 salth a n 27 ls		Myrtha Edmond	(Daughte	r)								,Maryland
, Baltimore,	of He of He Hitem	1	20a. Method of Disposition 1	L □ Bemoval from	20b. P	lace of Dispo emetery, cre	osition (Name matory or othe	of er place		Date 12,200	20c. Loc	cation - City or To	
ij	permit. Page Department of Important: If any injury or once.		' 4 □ Donation 5 □ Other (Spe	ocity)	Ga				emetery		Silv		ng,Marylan
Ball	permit Depart Import any in		21. Signature IT uneral Service Li	censee	1/10/1	// E	2. Name and A	Addres Iort	s of Facility On Comp	any Mort	icia	ns. Inc.	
	40260		222 Part Satar the disease are	ace	wy		ouu Ken	med	ly Stree	t,N.W.;V	Vashi	ngton,D.	C. 20011
			23a. Part1. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final	nly one cause on	each line.	n. Do not en	ter the mode of	ot dying	such as cardi	ac or respiratory a	arrest,		Approximate Interval Between Opset and Death
	Physician /Medical		disease or condition resulting in death)	a	YO CO	rdial	12	170	arctin				5 minute
	Examiner		1	Due to	or as a consequ	uence ot):							
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to	(or as a consequ	uence of):							
	cuted nd ransi	Examiner	that initiated events	c									
, 0,	icate be executed physician and s the burial-transit	E	resulting in death) Last	Due to	(or as a consequ	uence of):				100			_
8760,	cate b	dical		d									
9			IF FEMALE:	23c If yes ou	itcome of pregna	nev							
Box	eath atten I for u	clan	23b. Was decedent pregnant in the past 12 mooths?	1□Live	birth 2 Fetai	Ideath 3[Ectopic preg				2	3d. Date of delive Month	ry Day Year
P.O.	that the de ed by the detached	Physician/M	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unkr			(0,000	,					
	ires that signed t d be det	by P	Part II. Other significant condition	s contributing to c	death but not resu	ulting in the u	nderlying cau	se give	n in Part I.	23e. Did	tobacco us	e contribute to th	e cause of death?
rd	w require been sig should b									10	Yes 2□	No 3□ Prob	ably 4 Dhknown
Vital Records,	as s	Completed								24a. Was		24b. Were auto	osy findings available
- B		Con								perfo	ormed?	death?	
/ita	sician: Th certiticate rrector, pag	Be	25. Was case referred to medical examiner?	11. 201						ath Check onl	one		
of	Physi this c	2	1 Yes 2 No			ER/Outpatier		Othe	4 Nursing	Home 5 Res)
no	ding l h. After tuner	tlon	1 ■Natural 5 ☐ Pending		of Injury oth, Day Year)	28b. Time of Injury	M 28c.	. Injury Work	at ? es 2 □ No	28d. Describe	how injury	occurred	
Division	Attending Physician: r death. sctor: After this certitics by the tuneral director, I	fica	3 Suicide 6 Could no	t be 28e. Place	e of Injury - At ho	me, farm, str			03 2 110	28f. Location (Street and	Number or Rura	l Route Number
Ö	al or safter	Certification:	4 Homicide determine	build	ling, etc. <i>(Specit</i>)	1)	,,,,			City or To	wn, State)		, and the state of
61	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical (29a. Certifier 1 Certifying (Check only one) 1 Medical Ex	Physician: To the taminer: On the band man	e best of my know basis of examinat	wledge, death tion and/or in	occurred at t vestigation, in	the time	e, date and place inion, death occ	e, and due to the urred at the time,	cause(s) a date and p	and manner as st place, and due to	ated. the cause(s)
_	To the within 2 To the complet	Me	29b. Signature and title of certifler	17	nair	7	29c. L	icense	number		29d. Date	signed (Month, I	Day, Year)
			1 4/0.	Lew	1011			MD]	D51398		Ju	ne 2	,2004
			30. Name and addless of person wh										1
			James H. Shero,	M.D.; 5	75 Main	Stree	t; Sui	te	351; La	urel, Ma	ry1ar	nd 20707	

State Registrar 31. Date filed (Month, Day, Year)
JUN 0 8 2004

			State of Maryland / Department of Health a 1- For State Registrer Certificate of Death		al Hygien Reg. N	711111	20325
*	Physicia /Medic	an	1. Decedent's Name (First, Middle, Last) Lilliam R. muth	2. Da M O (ate of Death onth	h 2004	3. Time of Death
	Examin			lumb	la	Ic. County of Death	ard
	Funeral Director		5. Social Security Number 215 05 2570 6. Sex 1 Months 25 F 87 Yrs. 887 Yrs. 15 Usual Residence of Decedent	Min. 8-	ate of Birth fonth, Day, Yea 14–1916	9. Birth	place (State or Foreign ntry) rland
	Maryland f ahow	or	10a. State 10b. County 10c. City, Town or Location MD Howard Ellicott City				10d. Inside City Limits 1 ☐ Yes 2 📉 No
	or 28a- be notifi	Director	10e. Street and Number 10f. Zip Code		10g. C	Citizen of What Cou	ntry?
	ath v	ra	10142 Maplewood Drive 21042 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Ori	igin? (Specify V		United St	
920	72 hours after death with the Maryland natural; or flems 23a or 28a-f ahow areal Examilian frank be indiffied at	by Funeral	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, specify Cuban, Mexicar 1 □ Yes 2 □ No If Yes, Give Year or Dates:	n, Puerto Rican,	, etc.)	Black, White, Specify:	
21215-0036	⊆ 2 3	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during mos life. DO NOT use retired)	st of working	16b.	Kind of Business/In	,
	filed withi Hygiene. other than		1 Stenographer 17. Father's Name (First, Middle, Last) 18. Mothe	er's Name (First	t, Middle, Maide	Law Firm	1
Maryland	should be find Mental be marked of	To Be	Frank T. Reiter, Sr. Mar:	ie E. Ke	essler		-0.41
	and 2 sho saith and n 27 is mv		19a. Informant's Name/Relationship (Type, Print) Margaret C. Sellors/Sister 19b. Mailing Address (Street and Number 13100 Coastal Highway)				
altimore,	Pages 1 and 2 nent of Health int: if Item 27 iry or other to		20a. Method of Disposition 1	Date 6 –1 4–200		Location - City or To	
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee M01044 22. Name and Address of Facility 4112 Old Columb				
	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	^ ,		tien	Approximate Interval Between Onset and Death
	/Medical Examiner		Sequentially list conditions	rente	ia		
8760,	ate be executed hysician and he burial-transit	edical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):			3	
.O. Box 68	death certific e attending pl id for use as t	Physician/Medl	JF FEMALE: 23b. Was decedent pregnant in the past 12 ryonths? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)			23d. Date of deliv Month	ery Day Year
<u>α</u>	8 6 8	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I	1. 2	23e. Did tobacco	o use contribute to t	1/
Division of Vital Records,	The ate h page	Completed			24a. Was an autopsy performed?	death?	opsy findings available impletion of cause of
ita	ician: Th certificate rector, pag	Be (25. Was case referred to medical 26. Place	e of Death (Che	eck only one)		
) t	S 5	2	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 No			6 ☐Other (Special	(y)
ח		on:	27. Magner of Dealth 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?		Describe how in	jury occurred	
ivisio	ten leati tor: the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 4 Homicide determined investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Lo	ocation (Street a	and Number or Run ate)	al Route Number,
ני	To the Hospital or At within 24 hours after of To the Funeral Diract completely filled in by	edical Ce		nd place, and du ath occurred at t	ue to the cause the time, date a	(s) and manner as : and place, and due !	stated. o the cause(s)
	o the ithin 2 o the omple	Med	29b. Signature and title of certifier / 29c. License number		29d. D	Date signed (Month,	Day, Year)
	- s + 5		1 Syca 12 05087	0	Ju	me 10th	2004
(b) 00		30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Line C	lark	sulle	, פחת	21029
	St Regist	ate rar	STORY 7 A VIIIIA AND AND AND AND AND AND AND AND AND AN				

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** June 2004 10:45 AM Anne S. Moran /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Atlantic General Hospital Berlin Worcester 9. Birthplece (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Country) VA 1 M 2 XF 218-18-4331 Director 83 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or Iteme 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at Worcester Berlin MD 1X Yes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? US 306 Franklin Ave. 21811 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 X Married White 1 ☐ Yes 2€ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home fand permit. Pages 1 and 2 should be fit Department of Health and Mental Hy Important: If Item 27 is marked other eny injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rudolph Schminke Rosa Berry 218-18-433 Baltimore, Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 306 Franklin Ave., Berlin, Md. 21811 <u> Alfred J. Moran</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 Cremation 3 Removal from State St. Paul's Churchyard 6-12-04 Berlin, Md. *4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Funeral Service Licenses Ine Burbage 108 William St., Berlin, Md. ons that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. Part 1. Enter the disease, or complication shock, or heart failure. List only one as 108 William St., Berlin, Md. 21811 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Chstructive Pulmoning SYTUP resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, I want to be cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Completed by Physiclan/Medical Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☑ No detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. should be 1 Yes 2 No 3 Probably 4 DUnknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 ₹No of Vital To the Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death 2 Accident after death 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HEAITHWAY DRIVE BERLINMD BH 31. Date filed (Month, Day, Year) JUN 1 0 2004 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Moran, Anne

		1 - For State Registrar	State of Maryland		artment of H			ene - NS () () ()	20327
Physicia /Medic		Decedent's Name (First, Middle, Learnyl Anne Moo					2. Date of Death Month May 3	Day Yeer 1, 2004	3. Time of Death 1:00 a M
Examin		4a. Fecility Name (If not institution, gi 368 Wilett Driv 5. Social Security Number 6.		t hirthday)		r Location of Death rna Park It Under 24 Hrs.	8. Date of Birth	4c. County of Dea	rundel
Funeral Director			1 M 2XIF 46	Yrs.	Months Days	Hours Min.	Oct. 9,		thplace (State or Foreign ountry) PA
Be-f show	ctor		rundel 10c. City,	Town or Lo		a Park			10d. Inside City Limits 1 ☐ Yes 2 € No
23a or 2	Funeral Director	368 Wilett Driv	re			146		g. Citizen of What C US	-
permit. Pages 1 and 2 should be lied within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importment if time Z1 is marked other than "natural", or theme 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No tt Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 212 No	ispanic Origin? (Spanic Origin) In, Mexican, Puerto Specity:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
iene. rthan "natur the Medical	Completed	15. Decedent's E (Specify only highest gi	College (1-4or 5+)	(Give life.		ation during most of worki y Program	ing	b. Kind of Business Gallagher	•
ould be riled Mental Hyg arked other atic event,	To Be C	17. Father's Name (First, Middle, Las A. Thomas Moore	t)			18. Mother's Name Marion	e (First, Middle, Ma Fanelli	iden Sumame)	
and 2 snd saith and n 27 te m er traum		19a. Informant's Name/Relationship Janice Urban/Pa	rtner	368	Wilett D	and Number or Aura rive, Sev		City or Town, State,	Zip Code) 146
Pages 1 nent of He ent: If iter ury or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	☐Removal from State cen	netery, crer	sition (Name of natory or other plac Memorial	[⊛]	4	c. Location - City or Annapolis	
Departr Departr Imports any inj		21. Signature of Funeral Service Ho	See See See See See See See See See See		Name and Address Arranco & 95 Gov. R		A. Severi	na Park Fi na Park, i	uneral Home MD 21146
hysician /Medical Examiner		23a. Part Finter the disease, or co- sh.c.f. or heart failure. List only Immedia Cause (Final disease or condition resulting in death)	plications that caused the death, y one cause on each line. a. Due to (or as a conseque	By e (er the mode of dyin	g, such as cardiac o	or respiratory arres		Approximate Interval Between Onset and Death
hysician and the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. If the depth of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause	b. Due to (or as a conseque c. Due to (or as a conseque d.						
been signed by the attending ph should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. tf yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea 9 ☐ Unknown	eath 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
n signed b	by	Part II. Other significant conditions	contributing to death but not result	ing in the u	nderlying cause give	en in Part I.	23e. Did tobad		o the cause of death?
cate has bee	Completed						24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
which respins to American the law requires that he death certificate with the factor after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	VOutpatien 8b. Time of Injury	28c. Injun Work	4 ☐ Nursing Ho	me 5 (Check only one) me 5 (Check only one) 28d. Describe how	e 6 □Other (Spe injury occurred	cify)
within 24 hours after deatl	Certification:	3 Suicide 6 Could not 4 Homicide determined		e, farm, str	eet, factory, office		28f. Location (Stree City or Town, S	et and Number or Ri State)	ural Route Number,
in 24 hou he Funer pletely fill	edicai	29a. Certifier 1 Certifying P (Check only one) 1 Medicet Exa	hysician: To the best of my knowle miner: On the basis of examinatio and manner stated.	edge, death n and/or in	occurred at the time vestigation, in my op	ne, date and place, a pinion, death occurre	and due to the caused at the time, date	se(s) and manner as and place, and due	s stated. e to the cause(s)
diw Foo	Σ	29b. Signature/and (ittle/of centifier	uljuo		29c. License	9838	29d	Date signed (Mont	n. Day, Year) OY IS, UUL
		30. Nam, and ad ress of person who Stuaut E.	Selonichi	MO	Print) 900	Best	gate A	unapol	is, ull
Sta Registra		31. Date filed (Month, Day, Year) JUN 0 7	32. Registrar's Signatur	B. A	Anack)		_		

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 2004 **Physician** 7, McCulloch June 12:00 A M Elliott Margaret /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bowie Prince Georges 12001 Tweed Lane If Under 1 Year Months Days 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, 6. Sex Birthplace (State or Foreign Country) **Funeral** 1□ M 2 F Months Hours Min. 228-42-0646 1930 Virginia 74 Jan. Director Usual Residence of Decedent ould be filed within 72 hours after death with the Maryland Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Examinar must be notified at 1X Yes 2 No Director Maryland Prince Georges Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12001 Tweed Lane 20715 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No White Specify: Specify: 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene important: If Item 27 Is marked other than any injury or other traumatic event. The Me Campfire Elementary/Secondary (0-12) College (1-4or 5+) 4 Assistant Executive Director Girls 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Elliott Watson Marietta Allen ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gregory McCulloch- Son 12001 Tweed Lane, Bowie, Maryland 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 6/9/2004 **Huntt Crematory** Waldorf, Maryland 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licensee ponce 100 16000 Annapolis Road, Bowie, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed buriai-transit that initiated events resulting in death) Last been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a causes Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Year Month 5 Other (specify) 4 Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 ☑Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has page 2 autopsy performed? 1 ☐ Yes 2 ☐ No or Attending Physician: director, 25. Was case referred to medical examiner?
1 Tyes 2 Myo Be 26. Place of Death (Check only one) Hospital: Other: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 XNatural 5 Pending М death. investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 🗀 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral C 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Dey, Year) 2004 June 7, D0059228 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elvira Pasmanik, MD 3450 Ft. Meade Road, Suite 109, Laurel, Maryland 31. Date filed (Month, Day, Yeer) 32. Rigistrar's Signature State JUN 0 9 2004 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrer AMEND ITEM #29C PER PHY G832Certificate of Death Reg. No. 🖊 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 825AM Catherine Marie Milburn une /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hagerstown Washington 148 S. Locust St. If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 200F West Virginia Aug.24,1924 Director 79 219-12-1905 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County in of Health and Menial Hygiene.
If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumstic event, the Madical Examinar must be notified at 1 Yes 2 ☐ No Directo Hagerstown Washington Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21740 148 S. Locust St. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo 1 ☐ Never Married 2 🔀 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental Ponton Harry Loudon Susie Americus Hildebrand 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 148 S. Locust St. Hagerstown, Maryland 21740 Claude W. Milburn-Husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any injury or once. Cedar Lawn Mem. Park June 8,2004 Hagerstown, Maryland 21. Signature of Feneral Service License OSBOTHEAGINETENT Home, P.A. 425 S. Conococheague St. Williamsport,MD 21795 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Heart Failure **Physician** resulting in death) /Medical Due to (or as a consequence of): Cardiovascular Disease-Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by director, page 2 should be 2×100 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Chronic 24a. Was an amerm autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Sidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 25 No P 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division Hospital or Attending Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after deal To the Funeral Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D17591 address

DHMH 17 Rev 1/2001

State Registrar

Registrar DHIVIH 17 Rev 3/2001

Newgen

		1 - For State Registrar		partment of Health and ertificate of Death	Reg.	711111	20331
Physici /Medio			DBENG		JUNE 3	Day 2004	8:35 P M
Examir		4a. Facility Name (If not institution, give HOLY CROSS HOST 5. Social Security Number 6. Se	PITAL	4b. City, Town, or Location of Deal SILVER SPRING av) If Under 1 Year If Under 24 Hrs		4c. County of Death MONTGOMEI 1945 9. Birth	RY
Funeral Director			□M 2⊈F 58 Yrs	Months Days Hours Min	(Month, Day, Ye September	29 Ghar	place (State or Foreign untry) na W. Afric
within 7 z nous allet leedth with the Maryland ene. Than "natural", or Itema 23a or 28a-f show Ite Maid ral Exertither is ust be notified a	ctor	MD MONTGOMER	RY SIL'	VER SPRING			10d. Inside City Limits 1 □XYes 2 □ No
23a of 28	Funeral Director	10e. Street and Number 11509 FEBRUARY		10f. Zip Code 20904	GH	ANA W. AF	RICA
nal Hygiene. Ad other than "natural", or liema 23a or 28a-f show event, the Medical Exercisms in ust be notified at	Ď	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	3. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 Yes 2X No Specify: 1. Yes 2X No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Amer Black, White Specify: BLA	, etc.
iene. Than "natur the Medical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	Ge completed) (G	reedent's Usual Occupation ive kind of work done during most of wo e. DO NOT use retired) CHER	rking	. Kind of Business/I	ndustry
and Mental Hygis Is marked other raumatic event, II	To Be C	17. Father's Name (First, Middle, Last) OPANYIN AGYEKUM		MADAM	me (First, Middle, Maid AKUE AGOH	·	
当 2 に		19a. Informant's Name/Relationship (7. ISSAC OBENG/HUSBA		ailing Address (Street and Number or R 9 FEBRUARY CIRCLE			
Department of Hea Important: If item sny injury or otha once.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 1 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or some shock, or heart failure. List only of	Ft. Lin	22. Name and Address of Facility J 7474 Landover Road	26/2004 Br . B. Jenki d Landover,	ns Funera	Maryland 1 Home
nysician (Medical priial-transit priial-transit	iner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. MYELOGENOUS LI Due to (or as a consequence of): b	EUKEMIA			Onset and Death
ohysician and the burial-transit	dicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):				
by the attending phy tached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 Ectopic pregnancy 5 Other (specify)		23d. Date of delik Month	very Day Year
gned be de		Part II. Other significant conditions co	ontributing to death but not resulting in th	e underlying cause given in Part I.	23e. Did tobacc	co use contribute to	
ate has been signed by the attending phys page 2 should be detached for use as the	Completed by				24a. Was an autopsy performed 1 Yes 2 X	prior to co	opsy findings available ompletion of cause of 2 🏋 No
this certificate har ral director, page	Be	25. Was case referred to medical examiner?	Hospital:	Othor	ath (Check only one)		
After th funeral	ation: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Tim Inju	e of 28c. Injury at	dome 5 ☐ Residence 28d. Describe how in		ity)
within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, St	and Number or Rui ate)	al Route Number,
n 24 hours he Funeral pletely filled	Medicai	29a. Certifier 1 X Certifying Phyone 2 Medical Exam	vsician: To the best of my knowledge, d iner: On the basis of examination and/o and manner stated.	r investigation, in my opinion, death occ	urred at the time, date a	and place, and due	to the cause(s)
within 2 To the	Σ	29b. Signature and title of certifier	howak lu	29c. License number D005615	3	Date signed (Month)	OY
(5)		30. Name and address of person who of Kristie Nowak M.1	ompleted cause of death (Item 23a) (Ty D. 1500 FOREST GL	pe, Print) EN ROAD SILVER SPR	TNC MARVIA	ND 20010	

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** June 8, 2004 Mary E. O'Conner 6:15 Α /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e. Facility Name (If not institution, give street and number) Examiner Prince George 4503 Romlon Street, #T3 Beltsville If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number Days **Funeral** 1 □ M 2 🖾 F March 13, 1923 Illinois 81 339-16-5006 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral', or items 23e or 28e-f ahov Examiner was be notified at 1 Yes 2 □ No Maryland Prince George Beltsville Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4503 Romlon Street, #T3 20705 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ▼No Specify: δ 3X Widowed 4 □ Divorced White natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) than Elementary/Secondary (0-12) Proofreader U.S. Government 12 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be like Department of Health and Mental Hy Important: If Item 27 is marked other any injury or other traumaits access. 17. Father's Name (First, Middle, Last) Be O. R. Breen Louise Shipley ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13362 Triadelphia Rd., Ellicott City, MD 21042 Sharon Chamberlain/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Fort Lincoln Crematory 6-9-2004 Brentwood, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityFort Lincoln Funeral Home 21. Signature of Filheral Service / cens 3401 Bladensburg Rd., Brentwood, MD 20722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Pneumonia resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): burialphysicien Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day lor in the past 12 mon 4□ Pregnant at time of death detached 9 Unknown 9 Unknown signed by Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Senile Dementia, Chronic Obstructive Pulmonary Disease peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Congestive Heart Failure autopsy performed? page 2 2 🗆 No 1 Yes 2 X No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 ☐ Yes 2 XNo Certification: To this 27. Manner of Death 1 XNatural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 5 Pending s after de-ral Director: After 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours after To the Funeral Dir 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) nd title of certifier 29c. License number 29b. Signature D22780 June 9, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 7500 Greenway Center Dr., #430 Greenbelt, MD 20770 Peter M. Schissler, M.D. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

JUN 1 0 2004

Baltimore, Maryland 21215-0036

P.O. Box 68760,

of Vital Records,

		1 - For State Registrar	State of Maryland		artment <i>tificate</i>				giene	20333
		Decedent's Name (First, Middle, Last)						2. Date of Dea	ath	3. Time of Death
Physici /Medi			ven					June 7	2004	8:30 a M
Examir	er	4a. Facility Name (If not institution, give st		o le		own, or Loc apoli	ation of Deat	h	Anne A:	
Funeral		Genesis Elder Ca 5. Social Security Number 6. Sex	7. Age (In yrs. I		If Under 1	Year If	Under 24 Hrs		h 9.	Birthplace (State or Foreign
Director		197-20-0427	м 3/1 г	77 Yrs.	Months	Days H	ours Min.	sep 11	"1926 V:	irdinia
and		Usual Residence of Decedent 10a, State 10b, County	10c. City	, Town or Lo	cation					10d. Inside City Limits
Maryli f eho	Į.	Maryland Anne Aru	indel Da	vidso	nvil1	Le				M∑Yes 2 □ No
death with the Maryland rms 23a or 28a-f ehow	Irec	10e. Street and Number			10f. Zip 0	Code			10g. Citizen of What	Country?
th wit	al D	853 St. George E	Barber Rd.		21	1035			USA	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If term 27 is marked other than "natural; or flems 23a or 28a-f show eny injury or other traumatic event, the Medical Examination unit by notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	1	Was Decede f Yes, specif 1 □ Yes 🏖	fy Cuban, M	nic Origin? (S lexican, Puer pecify:	specify Yes or No- to Rican, etc.)		merican Indian, /hite, etc. nite
2 hou atura		15. Decedent's Educ	ation		ient's Usual		g most of wo	dina	16b. Kind of Busine	ss/Industry
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lled wi tygien her th		12th 17. Father's Name (First, Middle, Last)	0	Owne	r/Ope			me /First Middle	Beauty S	Shop
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should be and Mental marked o	은	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailin	ng Address ((Street and	Number or Ru	ural Route Numbe	r, City or Town, State	e, Zip Code) 21035
and 2 Balth a n 27 le	1	Dr. Eugene H. Owe					e Bar			onville, Md
Pages 1 nent of He ant; If then ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	(C) Tr	lace of Dispo enselves Par	Mattou Ment	neografia Poperatia	1 6-1	2-04 L	20c. Location - City ancaste	
permit. Pages Department of Important: If it eny injury or o		21. Signature of Funeral Service Licenses Lavry L. Sees	m00483	22 W	. Name and Im . Re 121 We	Address of eese est S	Facility & Son St. An	s Morti	lary, P.	A. 1401
Physician /Medical Examiner the prigital transit properties of the prigital physician and physician and physician and physician are properties of the physician physi	dical Examiner	23a. Part 1. Enter the disease, of complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to	uence of):	,	~ (o -		o o i i ospiratori y di		Approximate Interval Between Onset and Death
death certifis e attending p ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	lc. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pre Other (spe				23d. Date of Month	delivery Day Year
law requires that the as been signed by the 2 should be detache	by Ph	Part II. Other significant conditions cont	ributing to death but not resi	ulting in the u	nderlying ca	use given in	Part I.	23e. Did to	bacco use contribute	e to the cause of death?
w requires been sign should be								1 🗆 Y	es 2 DNO 3	Probably 4 Dunknown
The ate his page	Completed							24a. Was autop perfor 1 Yes	sy prior med? death	autopsy findings available to completion of cause of ?? 'es 2 \(\) No
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To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, str	eet, factory,	office		28f. Location (S City or Tow	itreet and Number or n, State)	Rural Route Number,
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To the within To the comp	Me	29b. Signature and title of Antifice	my			License nui) 6 3 6		29d. Date signed (Mo	onth, Day, Year)
			No 1108	8 171	Dona	to p	rind	Chal	v. MD	21419
St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Edgistrar's Signa		hart a					

Registre MEND#10e&19boen#16/14/04. RMJ, MCC Centificate of Death Reg. No. 0 13 14 2	1334
1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year	ime of Death
/Medical Victoriano 1. Orion June 3, 2004 1:	10 P M
Examiner 4a. Fecility Name (If not institution, give street and number) Washington Adventist Hospital Takoma Park Montgomery	
Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplece (Country) (Month, Day, Yeer) (Month, Day, Yeer)	State or Foreign
Director 219-45-5020 (X ^M ² 44 Yrs. Sept. 5, 1959 Philipp	ines
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Institute 1	ide City Limits
10a. State 10b. County 10c. City, Town or Location 10d. Institute 10b. Street and Number 10c. Street and Number 10]Yes 2∭XNo
> 44 U 10100 D.11 Ch	
13123 BOLLWE STREET 20904 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 2	ian,
Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. I Never Married 2 Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc.	n
Specify: ASIA Continue	.11
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 16c. Decedent's Usual Occupation (Give kind of working life. DO NOT use retired) 16b. Kind of Business/Industry (Computer Specialist Computer)	
College (1-4or 5+) 5+ Micro Computer Specialist Computer	
Tr. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 19. Part Continuous Continuou	
Epifanio Orion Columba Torniado 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code,	
19a. Informant's Name/Relationship (Type, Print) Daisy Orion, wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 13123 Bell Villest., Silver Spring, MD 20904	
Specify Mailed	ate
Geo. Washington Cem. June 8,2004 Adelphi, Maryl	
21. Signalura of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Av., Silver Spring, M	Compared to the Compared to th
23a. Farth. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	oximate ral Between
Physician Immediate crowdition disease or condition	and Death
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if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	
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edic	
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Od spanning to the cause of the contribute to the cause of the cause o	ie of death?
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24a. Was an autopsy find autopsy find autopsy find to complete	dings available
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O 1 Yes 2 Two Hospital: 1 Type Telephone 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death (Month, Day Year) 28b. Time of Injury at Work?	
1 Natural 5 Pending (Month, Day Year) Injury Work? 1 Yes 2 No 1 Yes 2 No 2 No 2 No 2 No 2 No 2 No 2 No 2 No 2 No 2 No 2 No No	
27. Manner of Death Section Sect	Number,
	ausa(s)
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Y.)	
A STATE OF THE STA	/
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	& Hula
ROOM D. ANDERSON WASHINGTON Admendist Hospited Tarama Park	My Da
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	()()

		1- State AMEND ITEM #3Ptate	er Print in Black ind er f Mary (3832/ 89287 Certi			ne
Physic /Medi Examii	cal	1. Decedent's Name (First, Middle, Last) FOR Y CIS 4a. Facility Name (If not institution, give street an UNIVERSITY OF MAT	I MO I VOII	R 4b. City, Town, or Location of Dee R Baltimare	6	Day Year 3. Time of Death 8:45 PM 4c. County of Death
Funeral Director		5. Social Security Number 212–12–3453 Usual Residence of Decedent	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hr Months Days Hours Min		Birthplace (State or Foreign
72 hours after death with the Maryland 72 hours after death with the Maryland naturel', or Items 23a or 28a-1 show deat Examiner must be notified at	Funeral Director	10a. State 10b. County Maryland Caroline 10e. Street and Number	10c. City, Town or Loca Presto	DN 10f. Zip Code		10d. Inside City Limits 11X Yes 2 □ No Citizen of What Country?
gas 1 and 2 should be filed within 72 hours after death with the Marylan gas 1 and 2 should be filed within 72 hours after death with the Marylan to 1 Health and Mental Hygiene. If item 27 is marked other than "naturel", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at	b	1 Never Married 2 Married 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Decedent Ever in U.S. dd Forces? 1943— s, Give or Dates: 1945	21655 as Decedent of Hispanic Origin? (es, specify Cuban, Mexican, Pue Yes 2 No Specify: nt's Usual Occupation	Specify Yes or No- rto Rican, etc.)	Inited States 14. Race - American Indian, Black, White, etc. Specify: Caucasian b. Kind of Business/Industry
ba filed within 72 hours at tall Hygiene. Id other than "naturel", or event, the Medical Exam.	Be Completed	(Specify only highest grade comple	ted) (Give kii	nd of work done during most of w O NOT use retired)	orking ame (First, Middle, Maid	Farming
ie, Mat y jailo. I and 2 should be filt. Health and Mental Hy tem 27 is marked oth	To	Arthur Linwood 19a. Informant's Name/Relationship (Type, Print) Pauline B. Pinder 20a. Method of Disposition	Wife PO Box 20b. Place of Disposit	Address (Street and Number or F 794, Preston, ion (Name of	Maryland	
permit. Pagas 1 an Depertment of Heal Important: If Item 2 any Injury or other once.		1 Burial 2 Cremation 3 Removal 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licentile	trom State Chesterfie	eld Cemetery 6/2 Name and Address of Facility Dre Funeral Home	22/2004 Ce	ntreville, Maryland
Physician / Medical Examiner partial fransit is partial fransit in par	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c	stroke e to (or as a consequence of):	the mode of dying, such as cardi	ac or respiratory arrest,	Approximate Interval Between Onset and Death
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aw requires us been sign 2 should be	Completed by Pl	Part II. Other significant conditions contributing		erlying cause given in Part I.	23e. Did tobaco	2 24b. Were autopsy findings available prior to completion of cause of
To the Hospital or Attending Physician: Tha taw Within 24 hours after death. To the Funeral Director: After this certificate has b completely filled in by the funeral director, page 2 s	To Be Com	25. Was case referred to medical examiner? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \) Hospital:	1 npatient 2 □ ER/Outpatient		performed 1 Yes 2 eath (Check only one) Home 5 Residence	death?
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Hospita 4 hours Funerel ely fillec	edical	(Check only 2 Medical Examiner: On	o the best of my knowledge, death of the basis of examination and/or inve- manner stated.	occurred at the time, date and place stigation, in my opinion, death occ	ce, and due to the cause curred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
To the I within 2 To the I complet	Me	29b. Signature and title of certifier Mutture 30. Name and address person who completed	M.D., cause of death (Item 23a) (Type Pr	29c. License number AV 417 6435 M int) FALLS Rock H	19 ZV. 15376 6	Date signed (Month, Day, Year)
St Regist	ate	Murtara Rizu	13221 p	FAILS Road	but Valley	J MD -21030

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of Maryland	d / Department of F Certificate of		ental Hygien Reg. No	0001	20336
¥ .	Physici /Medio		1. Decedent's Name (First, Middle, Las	M Pu	arell		2. Date of Death Month Da	8 2004	3. Time of Death
	Examir Funeral Director	ier		Maryland C	enter Bal-	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year, -18-1934) Сош	place (State or Foreign
	Maryland I-f show fied at	tor	Usual Residence of Decedent 10a. State 10b. County PA Franklin		Town or Location			1	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	th with the 23s or 28s	Funeral Director	10e. Street and Number 193 Garman Driv	J e	10f. Zip Code 1720:	1	10g. Ci	itizen of What Cour	
036	within 72 hours after deeth with the Maryland ene. then "neturel", or Items 23e or 28e-f show the Madigal Examiner met be notified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1XX es 2 ☐ No If Yes, Give Year or Dates: 75-86	If Yes, specify Cub	dispanic Origin? (Spec an, Mexican, Puerto F Specify:	cify Yes or No- lican, etc.)	14. Race - Americ Black, White, Specify:	
21215-0036	within 72 ho lene. r than "natur the Medical.	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire Master Serges	during most of workin d)	g 16b. k	Kind of Business/In Military	•
Maryland 2	nould be filed I Mental Hyg narked other natic event,	To Be C	17. Father's Name (First, Middle, Last) Herman R. Purnel			Deliah			
	Health and tem 27 is nother traum	1	19a. Informant's Name/Relationship (7) E. Catherine Purne 20a. Method of Disposition	ell wife	19b. Mailing Address (Street 193 Garman Date of Disposition (Name of	rive, Cham	bersbur,		1
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28s-f show any riqury or other traumatic event, the Madical Examiner must be notified at once.		1 Burial 2 Cremation 3 4 Donation 5 Other (Specify 21. Signature of Funeral Service Ocens	Smit	chsburg Crematory or other place chsburg Crematory 22. Name and Address 1	orium June	10,04 Sm	ithsburg	,Md.
8760,	Physician /Medical Examiner	icai Examiner	23a. Part1. Enter the disease, or compared to the control of the c	b. Aut Consequence of the leath one cause on each line. a. My 1	ence of):	ng, such as cardiac or	respiratory arrest.	OME	Approximate Interval Between Onset and Death
P.O. Box 68	Attending Physician: The law requires that the death certificate be executed r death. sctor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3 Ectopic pregnancy	1		23d. Date of delive	ery Day Year
	n requires that the bear signed by should be detailed.	þ	Part II. Other significant conditions co		Iting in the underlying cause giv	en in Part I.		use contribute to th	he cause of death?
Division of Vital Records,	: The law requicate has been page 2 should	Completed	J				24a. Was an autopsy performed?	prior to cor	psy findings available mpletion of cause of
Z K	ysician: The is certificate director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 X Inpatient 2 □ E	ER/Outpatient 3□ DOA Oth	26. Place of Death ler: 4 ☐ Nursing Hom	(Check only one) e 5 - Residence	6 ∏Other (Specif	(v)
o uo	ding Phys h. After this funeral di	tion: T	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	28b. Time of 28c. Injury Wor		3d. Describe how inju		
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	To the Hospital or within 24 hours afte To the Funeral Direction completely filled in the Funeral Direction of the Funera	Medical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	ysician: To the best of my know iner: On the basis of examinati and manner stated.	viedge, death occurred at the tir on and/or investigation, in my o	ne, date and place, ar pinion, death occurre	nd due to the cause(s d at the time, date and) and manner as st d place, and due to	tated. the cause(s)
2	Within To the complete	Me	29b. Signature and title of certifier Muttana	Zim M.D	29c. Licens	e number 16435 MRi		JUNO	
7	8 10 K.		30. Name and address of person who described the second se	Road 1	but valley	MD.	21030	,	
	Sta Registi		31. Date filed (Month, Day, Year).	32. legistrar's Signati	To produce				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 2. Date of Death Month g. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** June 8, 2004 4:56P Anne Corinne Perkins /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince Georges 3202 Moylan Drive Bowie 8. Date of Birth (Month, Day, Year) Feb. 28, 1 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 1 □ M 2 □ F Yrs. 63 1941 213-40-5215 Maryland Director Usuel Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f ehow Exercises must be extilled at Yes 2 No Director Prince Georges Bowie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ŏ 20715 3202 Moylan Drive USA Ітате 23а by Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. filed within 72 hours after ☐Yes 2 X No Yes, Give 1 Never Married 2K Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates "naturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry The Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) other then College (1-4or 5+) Hygiene. Counselor specialist Public Schools .. Pages 1 and 2 should be filed vitnent of Health and Mental Hygie tent: If item 27 is marked other tigury or other traumatic event, III. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter H. Gerwig, Jr. Olive Bowman 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3202 Moylan Drive, Bowie, MD 20715 John Carey Perkins-husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Metropolitan Crematory 6-10-04 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Importent: If eny injury or Alexandria, VA 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funer 6512 N.W. Crain Hwy., Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 2405 gmanths Metastatic nonsmall cell lung carcinone /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the attending physicien and hed for use as the burial-transit Hospital or Attending Physicien: The law requires thal the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown s been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Completed by 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 1□ Yes 2XNo certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 No this 28a. Date of Injury (Month, Day Yeer) Director: After the in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending 1 Natural
2 Accident 1 ☐ Yes 2 ☐ No death. investigation after death 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Vithin 24 hours a Th the Funeral L t 🗽 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified DO050498 14

State Registrar 31. Date filed (Month, Day, Year) JUN 1 1 2004

Maria Gillison

chn 22 A C CRB Lan 692 15 Orlean Street Solmon

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P.O. Box 68760

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Mary 27, 2004 15;25 **Physician** Linetta Parker /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Cheverly Prince George's Hospital Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State or Foreign Months | Days | Hours | Min. | February 27, 1943 | Washington, D.C. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖫 F 61 Yrs. 577-58-5119 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10b. County 10a. State Worle other then "natural", or Items 23a or 28a-f ebov vent, it a Medical Examiner must be notified at 1 X Yes 2 No Capital Heights Director Maryland Prince George's 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 20743 U.S.A. 5278 Marlboro Pike Apt. #203 Funeral filed within 72 hours after death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc Yes 2 No f Yes, Give Year or Dates: 1 Never Married 2 Married Black 1 Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify ģ 3XXWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Federal Overment (Retired) Husekeeper 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) .. Pages 1 and 2 should be fill thent of Health and Mental Hy tant: If item 27 le marked oth jury or othar traumatic eventiury or othar traumatic eventials. Be Martha Edwards Collian Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 814 Balboa Avenue Capital Heights, Maryland 20743 Lynda J. Parker (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages to Department of Himportant: If ite eny injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State June 5, 2004 Cedar Hill Cemetery Suitland, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility signature of Funeral Service Licensee ROLLINS FUNERAL HOME, INC. 4339 HINT PLACE, N.E. WASHINGTON, D.C. 20019 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardionyopathy /Medical Due to (or as a consequence of) **Examiner** Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit Hypertersion Due to (or as a consequence of) Box 68760 Physician/Medical Hyperlipidemia IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ SoNo 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 2X No 1 Yes 2X No 1 ☐ Yas Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ٩ 1 ☐ Yes 2 No 1 Inpatient **≱**ER/Outpatient 3 □ DDA 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification; After 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide Hospital To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier U 30. Name and address of pirson who completed cause death (Item 23a) (Type, Print) 10274 LATGE ARBOR My \$202 Metableville Morrison G. Melery dus 2. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 0 9 2004 Registrar

TODD NELSON PENWELL 04-3978 dap

unpend item#23a,27,28a-f,PER ME,G832,6/30/04eg
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrer	State of Ma	irylanu		tificate of			,	gien Reg. N		20220
	Physic	ian	Decedent's Name (First, Middle, TODD: NEEL Co.						2	. Date of De Month	D	ay Year	3. Time of Death
>	/Medi	cal	TODD NELSO 4a. Facility Name (If not institution,				4b. City, Town, o	v Location		JUNE		c. County of Death	9:16p M
	Examir	ıęr	14 EAST GREEN S				FUNKS'I		OI DOQUI		-	VASHINGTO	N
285	. Funeral Director		215-80-7078	. Sex 7. Age	(In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min. F	Date of Bir (Month, Da eb I			place (State or Foreign nto) y Land
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	h the Maryland r 28e-f show notified at	tor	Maryland Washing	eton	Funk	stown							1 √2 Yes 2 □ No
	ith the	Director	10e. Street and Number	,			10f. Zip Code				10g. C	itizen of What Cou	ntry?
	s 23c		14 East Green St				217					U.S.A.	
9800	filed within 72 hours after death with the Maryland Hygliene. ther than "naturel", or items 23s or 28e-1 show ont, the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 XNever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 □ Yes 2 ☑N If Yes, Give Year or Dates:			Vas Decedent of H Yes, specify Cuba ☐ Yes 2 No			fy Yes or No can, etc.)	•	14. Race - Americ Black, White, Specify: Wh:	
5-0	72 hour naturel	eted	15. Decedent's (Specify only highest	Education grade completed)		16a. Deced	ent's Usual Occup kind of work done O NOT use retired	ation during mos	st of working		16b. l	Kind of Business/In	dustry
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ylar	2 should be f and Mental a le marked of reumatic eve	To E	Roger Lewis Pen	vell					lred C				
e, Maryland 21215-0036	alt alt		19a. Informant's Name/Relationship Paul D. Penwell			6818	Kelly St	ore R	Road,	Thurmo	nt,	or Town, State, Zip MD 21788	Code)
Baltimore,	permit. Pages 1 ar Department of Hea Importent: if item: eny injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 4 ☐ Donation 5 ☐ Other (Spe	cify)			ition (Name of atory or other place g. Cremat		6/18/			ocation - City or To hsburg, N	
Bal	permit Depar Impor eny in		21. Signature of Funeral Septica Lic	Leeley 4	3/	61	5 EAST M	AIN S	T., T	HURMON	IT.	L HOMES, MD 21788	P.A.
			23a. Part. Enter the disease, or coshock, or heart failure. List on				r the mode of dyin	g, such as	cardiac or re	espiratory ar	rest,		Approximate Interval Between Onset and Death
7	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Narcotic]									Oriset and Death
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	р і	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequen	nce of):							
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89	tificate be executed ig physician and as the burial-transit	ledic		d.									
P.O. Box	Attending Physicien: The law requires that the death certificate be executed refeath. refeath. ector: After this certificate has been signed by the attending physician and extor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal de	ath 3 □ I	Ectopic pregnancy Other <i>(specify)</i>					23d. Date of delive Month	ry Day Year
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions	contributing to death but	not resultin	ng in the un	derlying cause give	en in Part I.				use contribute to th	e cause of death?
Division of Vital Records,	ysicien. The law requisicertificate has been director, page 2 should	Completed								24a. Was a autop: perfor	sy med?	prior to con death?	osy findings available apletion of cause of
Vita	icien: Th certificate rector, paç	Be	25. Was case referred to medical examiner?	Hospital:					of Death (C	hack only or	10)		
To a	Phys r this ral dir	. To	Yes 2 No 27. Manner of Death	I _ Inpatient	100000000000000000000000000000000000000	Outpatient b. Time of	3□ DOA Othe	4 140		5 X Resid		6 Other (Specify)
ioi :	nding Ph ath. r: After th e funeral	atlor	1 ☐ Natural 5 ☐ Pending investigate	28a. Date of Injury found onth, Day 1 6/16/04	$\mathbf{f}^{(ear)}$	9:10p	Work	(?`` ∕es 2 . Σ.ì	1000	DOWN.	O 47 11 11 GI	y occurred	
Vis	r Atte er dea recto	Certification:	3 ☐ Suicide 6 🛣 Could not determine	be as Blees of laive					28f.	Location (S. City or Town	treet an	d Number or Rural	Route Number,
	ortel or urs afte orel Dire	Cer		found in rea	sidence)				E. Gree	n St	., Funkstow	n, MD 21734
	To the Hospitel or Attendin within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical	one) Z X medical Ex	Physician: To the best of aminer: On the basis of e and manner state	examination	dge, death and/or inve	stigation, in my op	oinion, deat	d place, and th occurred a	at the time, d	ate and	I place, and due to	the cause(s)
	To To	-	29b. Signature and title of certifier	11 %			29c. License	number CME				17,2004	ay, Year)
			30. Name and address of person who	completed cause of dea	ath (Item 23	a) (Type, P	rint)						
			THEOPOREMIN					treet	, Balt	timore	, M	aryland 2	1201
	Sta Registra	_	31. Date filed (Month, Day, Year)	32. Registrar	s Signature	~ /	6 60	ans	/				

		1	For State Registrar	State of I	Marylan				ealth a D <i>eath</i>	nd Me		giene Reg. No.	0001	2031.0	
			Decedent's Name (First, Middle, Last	st)							2. Date of Dea Month	ath Day	Year	3. Time of Death	
	Physicia /Medic	_	Henry N.	Penny						J	une 6			2226 p ^M	_
	Examin		4a. Fecility Name (If not institution, give	e street and number	er)		4b. City.	Town, or	Location of	f Death			County of Deat		
, A		270	Prince George's					V⊝Ľ1 r1Year		24 Hrs	8. Date of Birt		ince G		_
	Funeral			ex 7. ∰M 2□F		last birthday) Yrs.	Months		Hours	Min.	(Month, Day	y, Year)	936 N.	hplece (State or Foreign nuntry) Carolina	
N 8	Director		212-38-0966 Usual Residence of Decedent		68						ren.	J ,(=	7.70 IV.	Calolina	_
	/land		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits	
	Man	tor	D.C. N/A		Was	hingt	on							1∭Yes 2 No	
	or 28	Director	10e. Street and Number				10f. Zi	Code				10g. Citi	zen of What Co	ountry?	
	23a		80 53rd Place	S.E.				0019				US			
	er des	Funeral	11. Marital Status	12. Was Decede Armed Force	s?	.S. 13.	Was Dece If Yes, spe	ident of H scify Cuba	ispanic Orig in, Mexican,	gin? (Spe , Puerto F	cify Yes or No- lican, etc.)		 Race - Ame Black, White 	e, etc.	
36	s afte	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 承 If Yes, Give Year or Date			1 🗆 Yes	2 E No	Specify:				Specify: B	lack	
0	hour furei	edt	15. Decedent's E			16a. Dece	dent's Usu	al Occup	ation		ĺ	16b. Ki	nd of Business/	Industry	_
5	n na	Completed	(Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4	or 5+1		kind of w		during most 1)	of workin	ig .				
212	d with giene er tha	mo.	3rd	0	5. 5.7	Se	elf :	Emp1	oyed				icklay:	er	
nd	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. ie marked other than "naturel", or Items 23a or 28a-f ehow remarke owent, the Medical Evantral must be notified at	Be	17. Father's Name (First, Middle, Last)							(First, Middle,				
Vai	Ment Ment arked	70	James Penny								Will:				_
Jar	2 sho		19a. Informant's Name/Relationship (r Town, State, 2		
6	1 and 1ealth am 27 ther t		Beatrice Penny 20a. Method of Disposition	(Wife)	20b. F	Place of Dispo	sition (Na	me of			lashin: ate		cation - City or	. 20019 Town, State	-
יסר	Ages nt of h		} Burial 2 ☐ Cremation 3 ☐		ata i	semetery, crei DSES (6/14	/04	Dri	ury, M	o.	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel; or Items 23a or 28a-1 show any injury or other treumatic event, In a Medical Examination in all the inclined all ange.		* 4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service Lice			2	2. Name a	nd Addre	ss of Facility	y			2		-
Ba	Departimbe		1	one Mac	483	V	√m.	Rees	e &	Sons	Mort	uar	y, P.A	•	
Øs.			23a. Pert1. Enter the disease, or com shock, or heart failure. List only	plications that cau	sed the deat	h. Do not en	ter the mo	de of dyin	g, such as	cardiac o	r respiratory ar	rrest,		Approximate Interval Between	
A.	Physician		Immediate Cause (Final disease or condition			ı1mona	ary	Arre	st					Onset and Death	
	/Medical		resulting in death)		as a conseq										
В	Examiner		Sequentially list conditions, if any, leading to immediate	D		ocard:	iə1	Infa	rcti	on				4 hours	
	ed sit	lne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a conseq	juence or):									
	xecut and	Examiner	that initiated events resulting in death) Last	c Due to (or	as a conseq	(uence of):									-
8760,	cate be executed only sician and the burial-transit			. 1									- 1		
9	tificati ng phy as the	Physician/Medical													_
Вох	dir dir	Z/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregna		Ectopic	pregnancy	,				23d. Date of del Month	*	
	0 0 0	sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No		at time of c		Other (MOHIII	Day Year	
0	t t	Phy	9 Unknown Part II. Other significant conditions			ulting in the .	undork in a	Cauca an	en in Part I		23e Did to	obacco i	use contribute to	the cause of death?	
	es be	by	Ischemic Hea			suiting in the c	maenying	odd30 gif	OTT HTT GIVE					robably 4 Unknown	
Vital Records,	neen nouk	Completed	15CHERIC HE	II C DISC	Lase						24a. Was	20	24h Ware a	utopsy findings available	-
3ec	e las has	mp									autor	psy rmed?	prior to death?	completion of cause of	
a	icien: The certificate ha		25. Was case referred to medical						OC Disease	of Dooth	(Check only of	2 🖾 No	1 Yes	2 □ No	_
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o	Phys er this eral di	-	27. Manner of Death	28a. Date of (Month,		28b. Time o		28c. Injur			28d. Describe				
ion	Attending Ph r death. ector: After th by the funeral	atio	1-∑Natural 5 Pending 2 Accident investigated	on	Day real)	lingury	М		Yes 2 🗆	No					
Division	r Atte	ertification:	3 ☐ Suicide 6 ☐ Could not determined	286. Place 0	f Injury - At h	iome, farm, st	treet, facto	ry, office		2	28f. Location (: City or Tox			ural Route Number,	
ā	To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the	O											\		
	Hospitel 4 hours a Funeral tely filled	edical	29a. Certifier 1 Tertifying P (Check only one) 2 Medical Exa	hysician: To the b miner: On the bas and manne	is of examina	owledge, dea ation and/or ir	th occurrences	d at the til	me, date an opinion, dea	id place, a ith occurre	and due to the ed at the time,	date and) and manner as d place, and due	s stated. e to the cause(s)	
	thin 2 the othe	Med	29b. Signature and title of officer	and manne	ii siaieo.	1	2	9c. Licens	se number			29d. Da	te signed (Mont	(h; Day, Year)	
	To To Con		1	M N	rel	1	S	D	27	3/	56	t	7/9	104	
			30. Name and address of person who	completed cause	of death (Ite					//	4509	Co	11232	PERKI	
_			ARVINS N	lehta	7/0		HI	noRe	A	19	#509	15 E	md	20340	
7	St	ate	31. Date filed (Month, Day, Year)	2004 32. 8	gistrar's Sign	ature	land.								

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year Month **Physician** Jennifer Ann Platt 11, 1:35 A June 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Edgewater 1748 Tacoma Road Anne Arundel If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□ M 2 🕇 F 220-56-3065 53 Yrs. Director Washington, D.C. 2-23-1951 Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State or 28a-f show event, the Medical Examiner must be nutified at 1 ☐ Yes 2 No Directo Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1154 Latrobe Drive 21401 USA or Items 23a death Funera 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2X No A Specify. Specify: White 3 Widowed 4 Divorced Year or Dates "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Rehab. Technician 12th Eldercare Pages 1 and 2 should be filed nent of Health and Mental Hygident: If item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles Barnett Krauss Myrtle Jean Leake item 27 is mail other trauma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alan L. Platt/Husband 1154 Latrobe Dr. Annapolis, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State Edgewater, Maryland permit. Page Department of Importent: If eny injury or * 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory 06-12-2004 22. Name and Address of Facility George P. Kalas Funeral Home ce Lic see 21. Signature of Fundal § 2973 Solomons Island Rd. Edgewater, MD 21037 ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, re. List only one cause on each line. 23a. Part 1. Enter the diseas shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death ŏ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) should be detached the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Xes 3 ☐ Probably 4 ☐ Unknown 2 No peen 24a. Was an autopsy performed?
1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 page 2 2 🗆 💢 certificate or Attanding Physician: rector. 25. Was case referred to medical MOTHER Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 1 ☐ Yes 4 Nursing Home 5 Residence 6 X Other (Specify) Certification: To 3 DOA funeral dir this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how inju voccurred 27. Manner of D After Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funerel Director: A 2 Accident completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospitel 29a. Certifier Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title 29d. Date signed (Month, Day, Year) rifie 30. Name and address of

Registrar **DHMH 17 Rev 1/2001**

State

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

P.O. Box 68760

of Vital Records,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 12:10 A^M 13 2004 June Gilbert Arthur Painter /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Future Care Chesapeake Anne Arundel Arnold If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 8,1910 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours Months 1ĂM 2□F 93 Yrs. Sept. 175-01-4067 Pennsylvania Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location r 28a-f ahow 10a. State 10b. County 1 ☐ Yes 2 X No Maryland Anne Arundel Arnold Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ral', or Items 23a or Examiner must be 21012 1249 Dogwood Road United States filed within 72 hours after death Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2XX No White Specify: Specify: þ 3XWidowed 4 ☐ Divorced "natural" Completed other than "natur 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 12 Chief Bailiff State Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ent of Health and Mental H nt: If item 27 is marked oth y or other traumatic avan Be Pages 1 and 2 should be 2 Elizabeth Unknown Joseph Painter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1249 Dogwood Road Arnold, Maryland Arthur Painter / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of the important: If ite any injury or of once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 6/17/2004 Brentwood, Maryland 4 □ Donation 5 □ Other (Specify) permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home, Inc 1 147 Duke of Gloucester St. Mila Annapolis, 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RONA 0 Pnysician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760, the attending physician Completed by Physician/Medical as the IF FEMALE: esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy page 2 should be detached for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 Tyes peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? res 2 No 2 No certificate 1 Yes 1 Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Cther: 4 ursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 NO 2 1 🗌 Yes 2 ER/Outpatient 3□ DOA this 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 1 5 Pending investigation Matural death. М 1 ☐ Yes 2 ☐ No 2 Accident after death Director: the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours at To the Funeral D Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier con pletely (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature of certifier of ath (Item 23a) Type, Print 4(0-1) MAT 31. Date filed (Month, Day, Year) State 15 2004 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			State of Maryland / Department of Health and Me		е	
			1- State Amend#s 5,8,perFH,FCHD,SL, Certificate of Death 6/7/0)4 Reg. N	2004	20343
	Physicia	in.		2. Date of Death Month D	ay Year	3. Time of Death
	/Medic		HERMAN EUGENIE PROCTOR 4a. Fecility Name (If not institution give street and number) 4b. City, Town, or Location of Death	May 31	c. County of Deat	10-
	Examin	er	4a. Fecility Name (If not institution give street and number) 4b. City, Town, or Location of Death FREDERICK		REDERI	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F G Yrs. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	B. Date of Birth (Month, Day, Year	9. Birth	hplace (State or Foreign untry)
24			Usual Residence of Decedent 213-42-1996		1944	
	with the Maryland a or 28a-f ahow Le notified at	7	10a. State 10b. County 10c. City, Town or Location FREDERICK FREDERICK			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	72 hours after death with the Marylar "natural", or Items 23e or 28e-f show ciral Examiner must be notified at	Funeral Director	10e. Street and Number 10f. Zip Code	10g. C	itizen of What Co	
	h with		132 KEY PARKWAY 21702	(l. S.	A
	after deat or Items ?	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces 13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto Ri	ify Yes or No- ican, etc.)	14. Race - Ame Black, White	
0000	s after	by Fu	1 □ Never Married 2 1		Specify B	ACK
3	72 hour		15. Decedent's Education 16a. Decedent's Usual Occupation	16b.	Kind of Business/	Industry
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7	lled w tygien her th		12 HS LADORER 17. Father's Name (First, Middle, Last) 18. Mother's Name (ISTRUCTION Sumama	an CUMPAN
land	lid be f lental F ked of ic ever	To Be	AdolPhus WEEdoN VIRGINI		CTOR	
ary	2 shoul and M is marl aumati		19a. Informant's Name/Relationship (Type, Print) ((() (FE)) 19b. Mailing Address (Street and Number or Rurati		00 -	
e e	s 1 and 2 f Health item 27 other tr	}	DEBORAH PROCTOR 132 Key PARKWA 20a Method of Disposition (Name of Da	1	Location - City or	170Z
E 0	8° = 5		1 N Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place)	/	LE DERI	
Saltin			4 □ Donation 5 □ Other (Specify)			HERAL HOME
n	permit. Departimport. any inj		Dary Collins 110 W. South ST.	FREDERI		
17	製		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	respiratory arrest,		Approximate Interval Between
>	Physician		tmmediate Cause (Final disease or condition resulting in death)	-hemic		Onset and Death
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- 19		er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	-		meat.
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ds,	es pe	by	Partition of the significant continuous continuous to deal out not resulting in the underlying cause given in Partition		2 □ No 3 1 Pro	
Ö	w requir been si should	lete		24a. Was an	24b. Were au	topsy findings available
Vital Records,	: The law cate has l	Completed		autopsy performed? 1 ☐ Yes 2 ☑ N	death?	topsy findings available completion of cause of
<u>ta</u>		Be C	25. Was case referred to medical examiner? 26. Place of Death (0 12166	20.10
	Physician: r this certifica ral director, p	မှ	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	e 5 Residence		cify)
פח	After fune	tion:	Natural 5 Pending (Month, Day Year) Injury Work?	8d. Describe how inj	ury occurred	
Division of	Attendi er death. rector: A by the fu	ifica	2 Action	Bf. Location (Street a		ral Route Number,
ā	rs afte rs afte af Dir	Certification:		City or Town, Sta		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier (Check only one) One) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and place, and manner stated. 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	nd due to the cause(d at the time, date a	s) and manner as nd place, and due	stated. to the cause(s)
	ro the vithin ? o the comple	Med	29b. Signature and title of certifier 29c. License number	29d. D	ate signed (Month	n, Day, Year)
)	C > F 0) X/A.Z. HEGAZIMO D44164	1	1/3/2	004
	16		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	MNZI	700 1	7- HEGAZ
	10		31. Date filed (Month, Day, Year) 32. Registrar's Signature	- 10 21	102 11	
	Sta Regist		31. Ďate filed (Month, Day, Year) 32. Registrar's Signature			

			1 - For State Registrar	State of	Maryland / Dep	artment of Hertificate of L		-	giene Reg. NG.	No.	11000
			Decedent's Name (First, Middle, La	nst)		Timodio or a		2. Date of De	ath II	la!	3. Time of Death
	Physicia		Ralph Edward RE	SH				June	May!	Year	6:14 PM
	/Medic Examin		4a. Facility Name (If not institution, gir		ber)	4b. City, Town, or	Location of Death		4c. County	of Death	V - 1
		•	Washington Coun	tv Hospi	tal	Hag	erstown		Wasi	hingt	on
	Funeral		5. Social Security Number 6.	Sex 7	. Age (In yrs. last birthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th v. Year)		lace (State or Foreign
	Director		218-30-8746	1 X M 2 □ F	73 Yrs.	William Says	1,0010	Jan. 2	25 1931		y1and
	w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or I	ocation				1	0d. Inside City Limits
	daryli f sho	ō	M 1	~*							1 ☐ Yes 2 X ☐ No
	28e-	ect	Maryland Washin 10e. Street and Number P.O.		Big Poo	10f. Zip Code			10g. Citizen of W	Vhat Coun	stry?
	with 3e or		11109 Garrison		oad		711		U.S.		, .
	death ms 2;	era	11. Marital Status	12. Was Deced	tent Ever in U.S. 13	Was Decedent of Hi	spanic Origin? (Si	pecify Yes or No)- 14. Race	e - Americ	
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 ia marked other than "natural", or items 23e or 28e-f show any injury or other traumatic evant, the Medical Examinat must be notified at once.	by Funeral Director	1 Never Married 2 Married	Armed Ford 1 Tes 2 If Yes, Give	2 X No	If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	n, Mexican, Puerti Specify:	o Rican, etc.)	Specify:	k, White, e	
21215-0036	hours ural',	q p	3 ☐ Widowed 4 ☑ Divorced	Year or Da	tes:					wn	ite
5	n 72 "nat	Completed	15. Decedent's E (Specify only highest gr	ade completed)	(Giv	edent's Usual Occupa e kind of work done o DO NOT use retired	luring most of wor	king	16b. Kind of Bu	siness/Ind	lustry
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	filed Hyg other ant,	Be C	17. Father's Name (First, Middle, Las		1 220	CK BIIVEI	18. Mother's Nan	ne (First, Middle,	, Maiden Surname		·+ <i>J</i>
Maryland	uld be Aental rked	To B	Wesley Resh				Franc	es (unk	known)	4	
ary	and A a ma	,-	19a. Informant's Name/Relationship	(Type, Print)	19b. Mai	ling Address (Street a	and Number or Ru	ral Route Numbe	er, City or Town,	State, Zip	Code)
	and 2 salth n 27 i		David Resh - Ne	phew		3 Lauran			n, Md. 2	1742	
ore	of He		20a. Method of Disposition 1 Darial 2 XCremation 3 [□Removal from S	20b. Place of Disp cemetery, cri	osition (Name of ematory or other place	9)	Date	20c. Location -	City or To	wn, State
altimore,	Pag ment ant: ury c		'4 □Donation 5 □ Other (Spec			own Crema	-	9/04			Maryland
Ball	permit Depart Import any in		21. Signature of Funeral Service Lice	insae	2.	Name and Addres			Funeral		
	40 = 4 d		23a. Part1. Enter the disease, or cor		Cumo	415 E. Wi			erstown,	Ma.	
			shock, or heart failure. List only	one cause on ea	ch line.		g, such as cardiac	or respiratory ai	rrest,		Approximate Interval Between Onset and Death
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	a	1	besity					
В	Examiner		1	Due to (c	r as a consequence of):	enal F	ailura				
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (c	r as a consequence of):			70		-	
	uted d ansit	min	Cause. Enter Underlying Cause (Disease or injury that initiated events	Re	strictive	LING	Disen	se			
Ć,	exec an and rial-tra	Examiner	resulting in death) Last	Due to (c	r as a consequence of):	<u>'</u>					
8760,	icate be executed physician and the burial-transit	dical		d							
Φ	± 0 €	a	IF FEMALE:								
Вох	death certifi e attending ed for use as	an/I	23b. Was decedent pregnant in the past 12 months?		ome of pregnancy th 2 Detail death 3	□Ectopic pregnancy			23d. Date Mon	e of deliver	ry Day Year
П	0 0	Physician/M	1 Yes 2 No	4□Pregna 9□Unknov		Other (specify)			Mon		Day rear
P.O.	hat the deby detac	Ph	Part II. Other significant conditions	contributing to dea	ath but not resulting in the	underlying cause give	n in Part I	23a Did to	obacco use contri	ibute to th	e cause of death?
Vital Records,	es un on	d by				on only mg data of give					ably 4 Unknown
200	w require been si should I	Completed						24a. Was		Vara autor	acy findings evaluable
Re	9 4	mp						autop	osy pi	rior to con eath?	osy findings available npletion of cause of
g	iician: Th certificate rector, pag	e Co	25. Was case referred to medical				Of Disease Of Das		-2	☐ Yes :	2 No
>	Physician: r this certificaral director,	0 3	examiner?	Hospital:	patient 2 ER/Outpatie	ont 3 DOA Othe	26. Place of Dea		dence 6 Othe	r (Specify	d
0	g Phy er thi	n: T	27. Manner of Death	28a. Date of			at		how injury occurre		
<u>o</u>	ath. r: Aft	atio	Natural 5 Pending investigation		, Day real/ Injuly		r res 2 □ No				
Division of	r Atte er de racto	Certification:	3 ☐ Suicide 6 ☐ Could not determined	28e Place	of Injury - At home, farm, s g, etc. (Specify)	treet, factory, office		28f. Location (S City or Tox	Street and Numbe	r or Rural	Route Number,
	ital o irs aft ral Di			4							
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Diractor: After this certific completely filled in by the funeral director,	edical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the t miner: On the bas and manne	pest of my knowledge, dea sis of examination and/or i	th occurred at the tim nvestigation, in my op	e, date and place, inion, death occur	and due to the cred at the time,	cause(s) and mar date and place, a	ner as sta nd due to	ited. the cause(s)
	o the vithin o the omple	Med	29b. Signature and title of certifier	and mailin		29c. License			29d. Date signed	(Month, [Day, Year)
)			> faind n	mley		Doe	560396		0610	8/0	>4
	SK 3		30. Name and address of person who	completed cause	of death (Item 23a) (Type	Print)	+ 1100	D-K+n	M		- d
4	7		30. Name and address of person who FAPID 31. Date filed (Month, Pay Year)	~ J 12 St	1ED 112	o Upai Col	ori Hag	612100	on IIIa	ryian	19
	Sta Registr		31. Date filed (Month, Pay Year)	2004 32. 8	gistrar's Signature	Joseph					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Yea **Physician** 2004 6:30 A^M JAMIE JUNE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGES HOSPITAL CHEVERLY PRINCE GEORGE'S If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1981 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday. Birthplace (State or Foreign Country) **Funeral** Days 11XIM 2□ F Yrs. February Director 216-96-3452 23 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Exacting most be notified at 1 X Yes 2 ☐ No Directo PRINCE GEORGE'S LANDOVER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a 1415 BELLE HAVEN DRIVE 20785 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumant. Black, White, etc. 1 X Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) STUDENT PRIVATE 10th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ISAAC J. REYES JAN HUNTER 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HUNTER/MOTHER 1415 BELLE HAVEN DRIVE LANDOVER, MARYLAND 20785 JAN 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State * 4 Donation 5 Other (Specify) 6/11/2004 RIVERDALE, MARYLAND RIVERDALE CREMATORY 21. Signature of Funeral Service Lansee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Part 1. Enter the disease, st complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** SCIDSIS resulting in death) /Medical Due to (or as a consequence of) heart failure Examiner onyestive Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events and resulting in death) Last Due to (or as a consequence of): the attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 ☐ Probably ☐Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2□ No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ 16 Certification: To Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 1 Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 04804 7104 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Green beli Hunover TUYK Was

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUN 1 1 2004

Baltimore, Maryland 21215-0036

P.O. Box 68760.

Division of Vital Records,

82. Registrar's Signature

		1 - For State Registrar	State of Maryl		artment of F rtificate of		Re	g. No. 1	2036
Physici /Medio	cal	Decedent's Name (First, Middle, Las Elma Radix Aa. Facility Name (If not institution, give			4b. City, Town, or	r Location of Do	2. Date of Death Month June 9,	Day Yea 2004 4c. County of Do	6:09
Examin Funeral	ner	Washington Adver 5. Social Security Number 6. Se	ntist Hospita	yrs. last birthday)	Takoma If Under 1 Year Months Days		s. 8. Date of Birth	Montgo	
Director		578-74-7135 Usual Residence of Decedent 10a. State MD Prince Ge	100	. City, Town or Lo	ocation		Feb, 7,		st Indies 10d. Inside City Lin
with the Ma Sa or 28a-f	Funeral Director	10e. Street and Number 6705 Coolridge F		Camp Sp.	101. Zip Code 20748	}	10	og. Citizen of What USA	1 XYes 2 ☐ Country?
within 72 hours after death with the Maryland ene. Than "natural", or items 28a or 28a-f ehow na Moulcal Exercities maint be inclified at	by Funera	11. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	i i	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛣 No		(Specify Yes or No- arto Rican, etc.)		merican Indian, hite, etc. Black
be filed within 72 ho tal Hygiene. d other than "natur event, the Moulcal	Completed by	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)		dent's Usual Occup kind of work done o DO NOT use retired gistered		orking 1	6b. Kind of Busine Medical	ss/Industry
	To Be C	17. Father's Name (First, Middle, Last) Carlos Arthur 19a. Informant's Name/Relationship (7	iuna Print)	10h Maili	ng Address (Street	Thelma	ame (First, Middle, M St. John Bural Route Number,		7in Cadal
1 and 1 Health tem 27		John Radix/Husba	nd	67		dge Rd,	Camp Spri		20748
permit. Pages Department of important: If It eny injury or o		1 M Buriai 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Similes Ling)) I	Resurrec	tion Ceme Name and Address	tery 6/	16/04 Strickland	Clinton, Funeral	
Physician /Medical Examiner		23a Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a con	leath. Do not ent	oud Allen	g, such as cardi	, Camp Spr ac or respiratory arre	ings, MD	Approximate Interval Between Onset and Deat
Ite be executed sysician and ne burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a con						
itie faw requires tratifie beatificetimizate at the been signed by the attending phy: page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b: Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pre 1 □ Live birth 2 □ I 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of o Month	delivery Day Year
been signed t	þ	Part II. Other significant conditions co	entributing to death but not	resulting in the u	nderlying cause giv	en in Part I.	23e. Did toba	-/	to the cause of deati
	Completed						24a. Was an autopsy perform 1 Tyes 2	prior t	
refeath. r death. sctor: After this certificate by the funeral director, pag	Certification: To Be	27. Manner of Death 11 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Jury (Month, Lay Yea	At home, farm, str	M 1	er: 4 ☐ Nursing y at	eath (Check only one Home 5 Resider 28d. Describe how	ice 6 Other (S) vinjury occurred eet and Number or	pecify) Rural Route Number,
To the hospitel or Attenting within 24 hours after death. To the Funeral Director: After completely filled in by the fune		29a. Certifier 1 Certifying Phy	building, etc. (Sc /sicien: To the best of my iner: On the basis of exar	knowledge, deati	h occurred at the tin	ne, date and place	City or Town,	use(s) and manner	as stated.
within 24 To the Fi	Medical	29b. Signature and title of certifier	and manner stated.	and a second second	29c. Licenso			d. Date signed Mo	
		30. Name and address of person who	ompleted cause of death	(Item 23a) (Type	Drint)	ě	. / !	1	1

DHMH 17 Rev 1/2001

			For State Registrar	State of Ma	-	partment of learning of learni			giene Neg. Ng? () () 4 2 (1347
	Physici	an l	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day	Vear	Time of Death
	*/Medic	al	Clifton Rife, 4a. Facility Name (If not institution, give s.			4h Cihi Tourn	or Location of Dea	June	4c. County	2004 5:4	40 A M
	Examin	ęr	4a. Facility Name (It not institution, give s. Prince George's Ho		enter	Cheve	_	un	-	ce Georg	œ's
	Funeral	- K ^D	5. Social Security Number 6. Sex	7. Age	(In yrs. last birthda	y) If Under 1 Year	If Under 24 Hrs		2		State or Foreign
п	Director		112-68-6256	M 2 F	34 Yrs.	Months Days	Hours Min	July 31		Brockpo	
	and	1	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d, In:	side City Limits
	Maryl	jo	Maryland Howard		Odenton	Maryland	1				∑Yes 2 □ No
	r 28e	irect	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Country?	
	th with 23£ o	Funeral Director	200 Langdon Farm C	ircle		21113		1	United	States	
	r dea	ner		2. Was Decedent 8 Armed Forces?		 Was Decedent of If Yes, specify Cut 	Hispanic Origin? (Specify Yes or No- rto Rican, etc.)		e - American Inc ck, White, etc.	tian,
36	rs afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☑ Yes 2 ☐ N If Yes, Give Year or Dates:	lo	1 ☐ Yes 2 🔀 No	Specify:		Specif	White	
21215-0036	72 hours after death with the Maryland neture!', or tems 23c or 28e-f show Jical Exar, it et must be codified at	ted t	15. Decedent's Educ	ation	16a. De	cedent's Usual Occu	pation		16b. Kind of B	usiness/Industry	
215	within 7, ene. then "n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5	life	ve kind of work done . DO NOT use retire	eduring most of wo ed)	onking			
	ed wil	Con	12	2	Pol:	ice Office		1000		forcemer	ıt
and	l be fil nta! H ed ott	Be	17. Father's Name (First, Middle, Last)					ime (First, Middle,	Maiden Suman	ne)	
Maryland	12 should be filed within h and Mental Hygiene. 7 Is marked other then "treumatic event, the Men	2	Clifton Rife 19a. Informant's Name/Relationship (Type	e. Print)	19b. Ma	illing Address (Stree	·	Hensley Rural Route Number	r, City or Town,	State, Zip Code	i)
	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. Item 27 Is marked other then "neturel", or Items 23c or 28e-f show other treumatic event, the Medical Erral in et must be rediffed at			Wife		Langdon			-		
Je,	of Health of Health litem 27 I		20a. Method of Disposition		20b. Place of Dis	position (Name of rematory or other pla	ace)	Date	20c. Location -	City or Town, S	tate
ii.	Page ment c ent: If		14 Burial 2 ☐ Cremation 3 ☐ Re 14 ☐ Donation 5 ☐ Other (Specify)	moval from State		coln Ceme	1	e 7, 2004	4 Bren	twood, M	laryland
Baltimore,	permit. Pages Department of H Importent: If ite eny injury or ot		21. Signature of uneral Service Licent)		22.PlarpendPdd		-		141 00	
	0. □ ≥ 0 0t		23a, Part1. Enter the disease, or complic	mains that sauced	the death. Do not	5538 Marl					0ximate
			shock, or beart failure. List only on Immediate Cause (Final	cause on each lin	e. / A	- (Asa.	1 - L	00	+	Inten	val Between et and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as	a consequence of):	0400	000	Tea	<u> </u>		
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	₽ ≅	iner	Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of j:						
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687	certificate iding phys ise as the		0								- 11
Вох	aath certifica attending ph for use as ti	M/us	23b. was decedent pregnant	lc. If yes, outcome 1 ☐ Live birth		3 ⊡Ectopic pregnand	cv			te of delivery	
	g o g	Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at 9☐Unknown		5 Other (specify)	-,		Mo	nth Day	Year
P.0	ac ac	Phy	Part II. Other significant conditions con	ributing to death bu	at not resulting in the	underlying cause g	iven in Part I.	23e. Did to	bacco use cont	ribute to the cau	se of death?
Records,	se un eo	d by	· • · · · · · · · · · · · · · · · · · ·		.			1 □ Y	es 2 No	3 Probably	4 Unknown
Sor	× 0 5	Completed						24a. Was a	an 24b.	Were autopsy fir	idings available
Re	Φ <u></u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u>	ошь						autop: perfor Yes	sy med? 2 □ No	prior to completio death? MYes 2□ N	
Vital	ician: Th certificate rector, pag	Be C	25. Was case referred to medical				26. Place of De	eath (Check only or		W. 199	
of V	Physician: this certific ral director,	To	Tes 2 INO	ospital: 1 Xnpatie		Herit SI DOX	1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	Home 5□Resid		er (Specify)	
n c	iner fler	on:	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Dal of Injur	Year) Injur	y Wo		28d. Describe h	ow injury occur	red f	
Division	Attending r death. ector: After	licat	2 Accident investigation 3 Suicide 6 Could not be	28e. lace i Inju		street, factory, office	1	28f. Location (S	treet and Numb	er or Rural Rout	e Number.
Ο̈́	after after Dire	Certification:	Homicide determined	building, ato	(Specify)	+ Bldo		SYOF (P. State)	1	
	pspits hours unere y fille		29a. Certifier 1 Certifying Phys								
	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	ledical	one)	and manner sta	ted.						
	To To Con	Σ	29b. Signature and title of certifier	2 1/1/			nse number	2		d (Month, Day,)	'ear)
	50		COM	MAD	noth (lac = 00) (m		C.M.E.		June 02	2, 2004	
	(0)		30. Name and address of person who co	a Cause of de	eath (Item 23a) (Tyl	_{De. Print)} L 1 Penn S t	reet, Ba	ltimore,	Maryla	nd 21201	
	Sta	ite	31. Date filed (Month, Day, Year)	32 Registra	ar's Signature				_		
k	Registi	ar	JUN 0 7 2004	Blown	. K A	all .					

		í	1 - For State Registrar	State of Mary	land / Dep	artment of F	lealth and	Mental Hy			2031	, ρ
	Discosioni di		1. Decedent's Name (First, Middle, Last)					2. Date of De Month	ath		3. Time of	Death
	Physici /Medic			ey Edward Re	eid			June	11 Day	2004	4:03	РМ
-	Examin	er	4a. Facility Name (If not institution, give s	treet and number)			r Location of Dea	th		County of Death	ר	
			8674 Bali Road 5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday	Ellicot		s. 8. Date of Bir		loward	nplace (State or	Foreign
	Funeral Director			M 2□F 36	Yrs.	Months Days	Hours Min		ii. Year) 1968	Col	ington	
	how		10a. State 10b. County	100	. City, Town or L	ocation					10d. Inside Cit	
	Be-fs	cto	MD Howard	l	Ellicot	t City					1 🗆 Yes	2X No
	vith th	Director	10e. Street and Number			10f. Zip Code			10g. Citiz	en of What Cor	untry?	
	s 23e	eral	8674 Bali Road	12. Was Decedent Ever	in II C 12	2104		Specific Ven ex No		ted Sta		
36	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Heath and Mental Hyglene. Important: if Item 27 is marked other than "natural", or Itams 23a or 28a-f show sayl injury or other traumatic event. If a Madical Era' is as most be notified at ange.	Completed by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☒ No		rto Rican, etc.)		Black, White		
Š	2 hou	ted	15. Decedent's Educ		16a. Dece	edent's Usual Occup	ation		16b. Kir	nd of Business/I		
21215-0036	thin 7	nple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)		e kind of work done DO NOT use retired	d) most of we	orking				
7	ygien ygien her th	Co		2	M	usician				f Emplo	yed	
and	tal H	Be	17. Father's Name (First, Middle, Last) George E. Reid					me (First, Middle, arie Capr		,		
ž	d Mer marke	ပ္	19a. Informant's Name/Relationship (Typ.	ne Print)	10h Mail	ing Address (Street					in Code)	
Maryland	id 2 s ith an 27 is i		George E. Reid/Fat			Bali Roa						
ē,	s 1 ar f Hea f Hea other		20a. Method of Disposition		b. Place of Disp	osition (Name of ematory or other place		Date		cation - City or 1		
E	Page: ent o nt: If I		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re `4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	letro Cr			4-2004	Cato	nsville	, MD	
Baltimore,	permit. Departm Importa any inju		21. Signature of Funeral Service License		01044 2	22. Name and Addre	ss of Facility Ha	erry H. W	Vitzk	e's Fam	ily FH	
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the		_				C CIC,	Approximate Interval Betw	
	Physician		Immediate Cause (Final disease or condition		NG	CANCE	R				Onset and D	
	/Medical		resulting in death)	Due to (or as a cor		CHIVEO					X 1EI	tics
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	sit ad	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cor	nsequence of):							
_	and and II-tran	хап	that initiated events resulting in death) Last	. Due to (or as a cor	sequence of):							
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687	ficate physics the		d									
Вох	death certificate be executed e attending physician and ad for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pro-		-			2	3d. Date of deliv	/ery	
Ď.	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 14 Pregnant at time		□Ectopic pregnancy □ Other (s <i>pecify)</i> _	/ 			Month	Day Ye	ear
<u>о</u> .	that the de ned by the a detached f	hys	9 🗆 Unknown	9□ Unknown								
Records, I	8 20	by	Part II. Other significant conditions con	tributing to death but not	t resulting in the i	underlying cause giv	en in Part I.			se contribute to]No 3 ☐ Pro		
CO	w require been si should t	Completed						24a. Was	an	24b. Were aut	opsy findings a	vailable
	The law cate has page 2 s	Julo							rmed?	prior to co death? 1 \(\sum \text{Yes}	ompletion of car	use of
ţa	ician: Th certificate rector, pag	a	25. Was case referred to medical				26. Place of De	1 ☐ Yes ath (Check only o		1 1 105	2L N0	
<u></u>	hysician: his certific I director,	To B	examiner? 1 ☐ Yes 2 🔀 No	ospital:	2 ER/Outpatie	int 3 DOA Oth	er: 4 🗆 Nursing I	Home 5X Resid	dence 6	Other (Speci	fy)	
0	r Attanding Phy er death. ractor: Alter this by the funeral of	ou:	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	of 28c. Injur Wor	y at k?	28d. Describe h				
sio	Attanding or death. actor: Alter by the fune	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				Yes 2 □ No					
Division of Vital	o 差 🖰 :=	Certification;	4 Homicide determined	28e. Place of Injury - building, etc. (Sp	pecify)			City or Tox	vn, State)	Number or Rur		91,
	To the Hospital within 24 hours a To the Funaral I completely filled	edical	29a. Certifier (Check only one) 1. Certifying Phys 2 Medical Examin	ician: To the best of my ler: On the basis of exar and manner stated.	knowledge, dea mination and/or in	th occurred at the tin nvestigation, in my o	ne, date and plac pinion, death occ	e, and due to the curred at the time,	cause(s) a date and p	and manner as solace, and due to	stated. to the cause(s)	
	To the within 2 To the complet	Ň	29b. Signature and title of certifier	00.		29c. Licens			29d. Date	signed (Month,	Day, Year)	
~	0		1 cul	ete M	D		6354			e 14, 2		
(3)	000		30. Name and address of person who con	mpleted cause of death 57 A6A	(Item 23a) (Type	Print) OO CAT	ZIN ANI	E RAIT	Mar	PE M	0 2/2) G
	Sta	te	31. Date filed (Month, Day, Year)	32 egistrar's S	Signature	JU CAT	DIV TIV	UZITEI	1110	N. 1911) a'a	A)
	Registr		JUN 1 4 200	14 Alen	A A	neve						

DHMH 17 Rev 1/2001

Estelle Marshall

			Please T	ype or Print				•	•	le.
			1 - For State Registrar	State of Man	•	artment of F <i>rtificate of</i>			giene _{Reg. N} o. () () ()	2031.0
l	Physici		1. Decedent's Name (First, Middle, Last) Estelle	Mars	hall	Rando	lph	2. Date of De Month June	ath	3. Time of Death 9:00 P M
	/Medie Examir		4a. Facility Name (If not institution, give s 4724 Englisl				or Location of Death	June	4c. County of	
	Funeral Director		5. Social Security Number 6. Sex		n yrs. last birthday) 69 Yrs.		If Under 24 Hrs.	8. Date of Bir (Month, Da Aug. 29	th c	D. Birthplace (State or Foreign Country) Florida
	fand ow		Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town or Lo	ocation			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	10d. Inside City Limits
	he Mary 28a-f sh	ector	Maryland Calve	rt	H1	untingto	nwo			1 ☐ Yes 2 ☐ X o
	23e or 2	Funeral Director	10e. Street and Number 970 Wilson Ro	ad		10f. Zip Code 2 (0639		10g. Citizen of Wh USA	at Country?
3-003g	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or Itema 23e or 28e-f show says injury or other traumatic event. It is modified. Examinate resulting at Once.		11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Eve Armed Forces? □ Yes 2 □ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🛣 No	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		American Indian, White, etc. Black
0-61717	d within 72 ho giene. Ir than "natu	Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 1 2	cation completed) College (1-4or 5+) 5+		dent's Usual Occup kind of work done DO NOT use retire Teacher	oation during most of worki d)	ing	1,6b. Kind of Busin	ness/Industry tary School
yland,	uld ba file Aental Hyg rkad othe tic event,	To Be C	17. Father's Name (First, Middle, Last) Houston]	Marshal	1	18. Mother's Name Estell		Maiden Surname) Si	b1ey
Mar	and 2 shousalth and No. 27 is male or traumale		19a. Informant's Name/Relationship (Tyr Glenda Randolph Da	Jackson/ ughter	19b. Mailii 472	ng Address (Street 4 Englis	and Number or Rura sh Court	Suit	ar, City or Town, St.: land, M	ate, <i>Zip Cod</i> e) D 20746
Dallinore,	Pages 1 ament of He tant: If iten		20a. Method of Disposition 1	emoval from State	Mt. 01i	ve UMC (Cem. 6/12			Frederick,M
0	Depart Import any in		21. Signature of Funeral Service License	Levell	. 1	2. Name and Addre	es Beach	well F Rd. F	uneral Prince F	Home red.,MD 2067
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Pancyea Due to (or as a co	die c	ter the mode of dyir	ig, such as cardiac c	or respiratory ar	rest,	Approximate Interval Between Onset and Death
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	onsequence of):					
,00,	ie ba executad /sician and e burial-transit	cal Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence of):					
O. BOX 607	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	∃Fetal death 3 [Ectopic pregnancy Other (specify)	,		23d. Date o	
ָר ה	res that ignad by be deta	by	Part II. Other significant conditions con	tributing to death but n		nderlying cause giv	en in Part I.			ite to the cause of death?
coins,	w requir	ompleted	Jamelic	- (000)	repres			1 L Y		Probably 4 ZUnknown re autopsy findings available
ב ה	n: The la icate has r, page 2	O						autop perfor 1 Tes	rmed2 prio	r to completion of cause of
O VIIAI	hysiciar his certif I directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	2 ER/Outpatier	nt 3 DOA Oth	26. Place of Death ler: 4 ☐ Nursing Hor		n	(Specify)
) IIOISIAI	ath. or: After the funera	ation:	27. Manner of Death 1-Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	ear) 28b. Time of Injury	f 28c. Injur Wor	y at 2		ow injury occurred	
	al or Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc. (5	- At home, farm, str Specify)	reet, factory, office		28f. Location (S City or Tow	Street and Number on, State)	or Rural Route Number,
	To the Hoapital or Attending Physician: The law within 24 burus after death. To the Funeral Director: After this certificate has completely filed in by the funeral director, page 2.	edical (29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best of mer: On the basis of exand manner stated	amination and/or in	h occurred at the tir vestigation, in my o	ne, date and place, a pinion, death occurre	and due to the o	cause(s) and manne date and place, and	er as stated. due to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	grwal D	10, Ph.A	29c. Licens	e number	- 1	29d. Date signed (A	
	<i>(</i>)		30. Name and address of person who coll I Yuing Sh	mpleted cause of death	n (Item 23a) (Type,	Print)	inglant	D.C	20010	
ı	Sta		31. Date filed (Month, Day, Year)	32. Registras	Signature	1. 10	1			

			1 - For State Registrar		Siale	n Iviai	ylanu / i		ificate		Death	a ivier	-	gier Reg. N	211111	20350
	Physici	an	1. Decedent's Name (First,										Date of De. Month		Day Yeer	3. Time of Death
	/Medi	al	Jonette	Dav		Rich	1	-					June	14	, 2004	1:20P
	Examir	er	4a. Fecility Name (If not ins.								Location of D	eath		4	4c. County of Deat	
	Funeral		Civista M 5. Social Security Number	ledica 6. Sex			(In yrs. last bii	rthday)	If Under 1 Y	ear	If Under 24 I	Hrs. 8.	Date of Birt	th .	Charle 9. Birt	holana (State or Foreign
- 8	Director		268-84-4123	1 🗆	M 2₹F			Yrs.	Months Da	ays	Hours N	Au	(Month, Da gust	^y .23	9. Birt 9. 7	Ohio
	pue *		Usual Residence of Decede 10a. State 10b. C			1	10c. City, Tow	m or Loca	ition		-			-		10d. Inside City Limit
	Marylan f ehow	ō		arles	1		Walc									1 Tes 2 TN
	1 the 1	rect	10e. Street and Number	larica	<u> </u>		Walt	TOLL	10f. Zip Cod	de				10g. (Citizen of What Co	
	death with the Maryla ime 23e or 28e-f ehor Linual by frolified at	alD	11245 Hess	Cou	ırt				206	01	_				USA	
9	within 72 hours after death with the Maryland ane. than "naturel", or Iteme 23e or 28e-f ehow the Medical Examinar must be notified at	Funeral Director	11. Marital Status 1 ☐ Never Married 22	- 1	2. Was Dec Armed Fo 1 Tyes If Yes, Gi	orces?			as Decedent es, specify (_	spanic Origin? n, Mexican, Pu Specify:	(Specify uerto Rica	Yes or No- an, etc.)	-	14. Race - Ame Black, White	e, etc.
903	Jrel',	Completed by	3 ☐ Widowed 4 ☐ Div		Year or E	Dates:				NAO	эрөспу:				Specify:	White
15-	72 hours "naturel",	lete	15. De (Specify only	edent's Educ highest grade	ation completed)		16a	Give kii	nt's Usual Od nd of work do	ccupa one d	ation furing most of)	working		16b.	Kind of Business/	Industry
12	filed within Hygiene. other than ent, Ite M	ошо	Elementary/Secondary (0	-12)	College (1-4or 5+)			Homen	_					Hon	ne
b	il Hygid other	Be C	17. Father's Name (First, M								18. Mother's	Name (Fi	irst, Middle,	Maide		
/lar	2 should be filed within and Mental Hygiene. Is marked other than sumatic event, the Me	To B	Paul Franc	is Ea	ton						Alma	Dot	wler			
Maryland 21215-0036	s 1 and 2 should I Health and Men item 27 is marke other traumatic	9 9	19a. Informant's Name/Rel												or Town, State, 2	
e,	os 1 and 20 Health item 27		Robert Ric	h/Hus	band		20b. Place o				Court	, Wa.			D 20601 Location - City or	
Jor			1 Burial 2 Crema		emoval from	State	cemete	ry, crema	tory or other	place	01s 6/				•	Hall, MD
Baltimore,	permit. Pege Department of Important: If any injury or once.		' 4 ☐ Donation 5 ☐ Ott		Θ Α	r	100945								L HOME,	
Ba	Depa Impo eny i	Į,	1 Main C	. Ech	I)										.,MD. 20	
68760,	rificate be executed by physician and as the burial-transit	al Examiner	23a. Pert1. Enter the disea shock, or heart failure Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infittated events resulting in death) Last	List only on	Due to	oach line.	consequence	of):			lar d	1				Approximate Interval Batween Onset and Death
687	ificate g phys	edical		- 4												
.O. Box	requires that the death cert een signed by the attending nould be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregna in the past 12 months' 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	nt		oirth 2 nant at tin	pregnancy Fetal death ne of death		ctopic pregna Other <i>(specif</i> y						23d. Date of deli- Month	very Day Year
Δ.	that in the part of the part o	by Ph	Part II. Other significant co	nditions con	tributing to d	eath but i	not resulting is	n the und	erlying cause	e give	n in Part I.		23e. Did to	bacco	use contribute to	the cause of death?
rds	w requires been sign should be	ed b										_ 1	1 □ Y	es :	2,111 No 3 □ Pro	obably 4 Unknown
Division of Vital Records,	The law te has b age 2 st	Completed										-	24a. Was a autop perfor	sy med?	prior to c death?	topsy findings available ompletion of cause of
ita	ician: T certificat rector, p	Bec	25. Was case referred to m examiner?	edical							26. Place of [2 ,⊠ N ⊓e)	10 10185	2□ 140
of V	Physician: this certific al director,	P	1 Yes 22 No	Н		Inpatient			3 DOM	Othe	4 Nursing				6 Other (Spec	ify)
on C	Miter	ion		ending vestigation	28a. Date (Mon	of Injury th, Day Y	(ear) 28b.	Time of Injury		Work'	at ? ′es 2 □ No	28d.	Describe h	ow inj	ury occurred	
Division	No Hospitel or Attending 124 hours after death. Ne Funerel Director: After pletely filled in by the fune	Certification;	3 ☐ Suicide 6 ☐ C	could not be etermined	28e. Place build	of Injury ing, etc. (r - At home, fa (Specify)	arm, stree			2 2 110	28f.	Location (S City or Tow	treet a n. Sta	and Number or Rui te)	ral Route Number,
	• Hospitel or Al 24 hours after of • Funerel Directetely filled in by	Medical Co	29a. Certifier 12 Ce (Check only one) 2 Me	rtifying Phys dical Examin	er: On the b	best of r	xamination an	e, death o	ccurred at th	ne time	e, date and pla inion, death or	ace, and	due to the c	ause(s) and manner as nd place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of c	ertifier /)) /	states			29c. Lic	ense	number		2	29d. D	ate signed (Month	, Day, Year)
	- > F O		$\rightarrow \mathcal{N}_{\mathcal{C}}$	W					D-5	22	89			(6/15/0	4
1	22/1		30. Name and address of po	erson who co	npleted caus	se of deat	th (Item 23a)	(Туре, Рг				-				
K	L'Y		Nalin Math	ur, M	D 10	St.	Patr	icks	s Dri	ve	Suite	e 40)4 Wa	1d	orf,MD	20603
		1	31. Date filed (Month. Day.	Year	1 32.05	(anietrarie	Signature								,	

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Morus Ray, Year) 2004

JONETTE RICH

ORIGINAL

Sperker

			1 - For State Registrar	State of Mar		artment of rtificate of		R	eg. No	n.L.	20251
н	Physici	an	1. Decedent's Name (First, Middle,	Last)				2. Date of Dear	h Day	Year	3. Timelet Death
	/Medi		Alfred	Archie		Smith,	Sr.	June	14,	2004	9:15 P ^M
ŧ.	Examir	ner	4a. Facility Name (If not institution,			-	or Location of Deat	h		ty of Death	
			6 Oak Tree Lane			William				shing	
	Funeral Director		5. Social Security Number 220–16–1266	5. Sex 7. Age ((In yrs. last birthday)	Months Days	if Under 24 Hrs Hours Min.		1926	Cour	place (State or Foreign http) 7 Land
	land M		10a. State 10b. County	1	Oc. City, Town or Lo	ocation				1	0d. Inside City Limits
	Mary -f sh	ঠ	MD Washing	gton	Williams	enort				İ	1 X Yes 2 □ No
	r 28a	rec	10e. Street and Number	3-0	W-11-1-000	10f. Zip Code		1	0g. Citizen of	f What Cour	ntry?
	h witi	by Funeral Director	6 Oak Tree Lane	Apt. E		21795	5		U.S.A	۸.	
	deat	ner	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of	Hispanic Origin? (S ban, Mexican, Puert	pecify Yes or No-	14. Ra	ce - Americ	an Indian,
ဖွ	or ite	臣	1 Never Married 2 Married			1 □ Yes 2 ☑ No		to Hican, etc.)		ack, White,	
ဋ္ဌ	ral'.	5	3 Widowed 4 Divorced	Year or Dates:	1944	10165 20 NO	э эрөсну.		Spec	^{ity:} Whit	:e
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show ha Medical Exacili or mat be notified at	Completed	15. Decedent's (Specify only highest		(Give	dent's Usual Occu kind of work done	during most of wor	rking	16b. Kind of	Business/Inc	dustry
7	vithin ne. han	ם	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire			T - 1	1.0	
2	lited v lygie lher i nt, th		12 17. Father's Name (First, Middle, La	act)	Equipa	nent Spec	1	ne (First, Middle, M			rernment
and	od ol	Be	Robert F. Smith				Reita		malden Suma	.me)	
Ë	should be ind Mental I	ဥ	19a. Informant's Name/Relationship		10h Mailie	A Jalance /Ctro-	t and Number or Ru		0: -		
Maryland	d2s than 71s trau		Shirley L. Smith								
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Exacting Innat Le notified at ance.		20a. Method of Disposition		20b. Place of Dispo		ane Apt.		SPORE :		21795 wn State
Baltimore,	ages int of t: If in		1 ☐ Burial 2 X Cremation 3	LINGINOVALITION STATE							
₩	artme artme ortan injury	1	' 4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Lice		Smithsbur		ess of Facility Re		mithst		
Ba	permi Depa Impo any is		S. Marle S				sylvania A				
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that caused the	e death. Do not ent	er the mode of dy	ing, such as cardiac	or respiratory arre	st,	I S FILD	Approximate Interval Between Onset and Death
E	Physician /Medical		Immediate Cause (Finat disease or condition resulting in death)	_ a	ryelod	45/1/05	tu sy	udran	ne_		6 week
	Examiner			Due to (or as a c	consequence of):		/				
		<u>ت</u>	Sequentially list conditions, if any leading to infraediate cause. Enter Underlying Cause (Disease or injury	b Due to (or as a c	ionsaguence of):						
	t ted	Examiner	cause. Enter Underlying Cause (Disease or injury								
Ć,	ate be executed hysician and the burial-transit	Exa	that initiated events resulting in death) Last	C Due to (or as a c	consequence of):						
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89	ifficat g phy as th	edi									
Вох	The law requires that the death certificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of					23d. Da	ate of delive	rv
m	that the death hed by the atter detached for u	icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 [4 ☐ Pregnant at tirr		Ectopic pregnanc Other <i>(specify)</i> _	:y				Day Year
0.	t the by the ache	hys	9 Unknown	9□ Unknown							
	res tha igned be det		Part II. Other significant conditions	s contributing to death but r	not resulting in the ur	nderlying cause gi	ven in Part I.	23e. Did tob	acco use con	tribute to th	e cause of death?
ğ	w require been sig should b	edit	Itiabetes Ma	Ellitus, 1	9 thecos	Clerox	ec	1 ☐ Ye	2 00	3 🗌 Proba	ably 4 Unknown
Records,	aw re s bee 2 sho	Completed by	Unacular 1	Disease				24a. Was an		Were autop	sy findings available
æ	The fav te has age 2	E	- VIII- VIII- VIII- VIII					autopsy	ed?	death?	npletion of cause of
g	ysician: The is certificate hadirector, page	a)	25. Was case referred to medical				26 Place of Dea	1 ☐ Yes 2 th Check on one		1 🗆 Yes	2[] NO
>	Attending Physician: r death. ector: After this certifice by the funeral director, p	To B	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient	2 ER/Outpatien	t 3 DOA Ott		ome Keside		er (Specify	1
0	ding Phy h. After thi funeral o		27. Manner of Death	28a. Date of Injury (Month, Day Y	ear) 28b. Time of	28c. inju Wo		28d. Describe how			
0	ttendir feath. for: Af the fur	atlo	1 Natural 5 Pending 2 Accident investigat	tion	and many		Yes 2 □ No				
Division of Vital	r Atte	tific	3 Suicide 6 Could not 4 Homicide determine		- At home, farm, stre	et, factory, office		28f. Location (Str. City or Town,	et and Numi	ber or Rural	Route Number,
	ospital or Atten hours after deat unerat Director: ly filled in by the	Certification:						ony or rown,	Olaro,		
	To the Hospital o within 24 hours af To the Funeral D completely filled in	edical	(Check only 2 Medical Ex	Physician: To the best of n taminer: On the basis of ex	amination and/or inv	occurred at the ti	me, date and place,	and due to the car	use(s) and make	anner as sta	ited.
	To the Hos within 24 h To the Fur completely	Med	5,10,	and manner stated	1.						
	wit Cor	~	29b. Signature and title of certifier	Marin hi	/-	29c. Licens			d. Date signe		ay, Year)
	6X1		V unay El	Many w		102			le i l	`	
W.	X		30. Name and address of person wh	o completed cause of deat	h (Item 23a) (Type, I	Print)	t, Hage		, , , ,	0 -	21711
2)			31. Date filed (Month, Day, Year)	24 04 32. Segistrar's	Signature	11 74 186	1, Nage	15 TOUN	· wi	/	1/10
	Sta Registr		JUN I 5	2004 Janen	D. 1	we	,				

			State of Maryland /	Depa		of He	alth a		ental Hy	giene Reg. No. /	200		0.00
zeli.	45		Registrar 1. Decedent's Neme (First, Middle, Last)						2. Date of De	ath	4 U (14	3. Time of Death
	Physicia		MARY JOSEPHINE STANLEY LUTSON						Month MAY	Day 18,		9ar 004	12:00P ^M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, To	wn, or Lo	ocation o	f Death			County of		
			6413 WHITE OAK AVENUE					HILL					ORGES
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last.	birthday) Yrs.	If Under 1 Months C		Hours	Min.	8. Date of Bir (Month, Da	h y, Yeer)	1.6	Birthpl Coun	ace (State or Foreign
le.	Director		191 12 6715 87 Usuel Residence of Decedent	113.					JUL. 07	, 19	16	FLOR	LDA
	/land		10a. State 10b. County 10c. City, To	wn or Lo	ocation							10	Od. Inside City Limits
	Mary a-f-eh	to	MARYLAND PRINCE GEORGES TEMPI	LE H	ILLS								XX Yes 2 □ No
	or 28	Director	10e. Street and Number		10f. Zip C	ode				10g. Citiz	en of Wh	at Coun	try?
	death with the Maryland sms 23s or 28s-f show if trust be coulded at	rai	6413 WHITE OAK AVENUE		1	2074				UNIT			
36	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other then "naturel", or items 23s or 28s-1 show event, I're Medical Exercities must be collified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married **XX Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes **XX No If Yes, Give Year or Dates:		Was Deceder If Yes, specify			gin? (Spe , Puerto I	cify Yes or No Rican, etc.)			White,	
Maryland 21215-0036	in 72 hou n "natura Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0·12) College (1·4or 5+)	(Give	dent's Usual (kind of work DO NOT use	done dur	on ring most	of working	ng	16b. Kin	d of Busi	ness/Ind	lustry
7	d within giene.	mo.	11TH	D	OMESTI	3							
2	be filed tal Hygi d other event, ti	Be (17. Father's Name (First, Middle, Last)			18			(First, Middle	Maiden S	Sumame)		
ya		2	ERVIN STANLEY					IE H		0.1	T . 0		0-4-1
<u>a</u>	12 sho h and 7 is m iraum								I Route Numb				
	ges 1 and 2 should t of Health and Mer if Item 27 is marke or othar traumatic		EARLEAN STANLEY GROGAN / SISTER 20a. Method of Disposition 20b. Place	of Disp	3 WHIT] osition (Name	of	KAV		TEMPLE ate				wn, State
2			XX Burial 2 Cremation 3 Removal from State		matory`or othe		 סי עם	6 MA'	v 2004	DOM	ΩD A	DΛ	
Baltimore,			21. Signature of Funeral Service Licensee						Y 2004 HOME OF		ORA,		•
ñ	permit. Departimport. Import. eny inj		1. T. Warshell		ARSHALI 308 SU:				HOME OF	LAND	YLAN. MD	207	46
6			23a. Part1. Her the disease, or complications that caused the death. Shock, or heart failure. List only one cause on each line.	o not en	ter the mode	of dying,	such as	cardiac o	r respiratory a	rrest,			Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. METASTATIC Elements of the condition o		STRIAL	CAR	CINO	MA					Onset and Death
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Oisease or injury	ce of):									
	ate be executed nysician and he burial-transit	Examine	that initiated events C.										
760,	e exe	EX	resulting in death) Last Due to (or as a consequent	ce of):									
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O. Box 68	The law requires that the death certificate to the has been signed by the attending physic page 2 should be detached for use as the bearened to the states as the total states as the bearened to the states as the states as the states as the states as the states as the states as the states as the states as the states as the states as the states as the states are states as the states are states as states as the states are states as the states are states as states are states as states are states as states are states as states are states as states are states as states are states as states are states as states are states as states are states are states as states are states as states are states as states are states as states are states as states are states as states are states as states are states as states are states are states as states are states as states are	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 4 Pregnant at time of death 9 Unknown		□Ectopic preg □ Other (spec					2	3d. Date Mont		ry Day Year
1	es that the de igned by the a be detached t		Part II. Other significant conditions contributing to death but not resulting	g in the i	underlying cau	se given	in Part I.		23e. Did 1	obacco us	e contrib	ute to th	e cause of death?
g	uires sign ld be	d by	DEMENTIA						1 🗆	Yes 2□]No 3	☐ Prob	ably XXUnknown
Vital Records,	e law require has been si je 2 should b	Completed							24a. Was		pri	ere autor or to cor ath?	osy findings available npletion of cause of
a	ician: The l certificate ha rector, page								1 ☐ Yes	XX No		Yes	2□ No
Ĭ	Physician: this certificated fra director, it	Be C	25. Was case referred to medical examiner? 1 ☐ Yes YN No Hospital: 1 ☐ Inpatient 2 ☐ ER	Outnatie	nt 3 DOA	Other			n <i>(Check only i</i> me XX Resi		Other	(Specifi	4)
o	Phys or this oral dir	. To	27. Manner of Death 28a. Date of Injury 28	b. Time		. Injury a Work?			28d. Describe				7
0	Attending or death.	atlor	XXNatural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury	м	Work? 1 ☐ Ye	s 2 🗌	No					
Division	al or Attendi s after death. Il Director: A od in by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	, farm, si	treet, factory,	office			28f. Location (City or To			or Aura	l Route Number,
)	To the Hospital or Attending I within 24 hours after death. You the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier (Check only one) 1 X X ertifying Physician: To the best of my knowle 2 Medicel Examiner: On the basis of examination and manner stated.										
	To the within To the comp	Ž	29b. Signature and title of certifler		29c.	License r	number						Day, Year)
			trame efth 985 trypu	- h		D280	79			JUN	E 05	, 20	004
			30. Name and address of person who completed cause of death (Item 23			T mer-		D	·	T MCT		3.00	20705
	-		FRANCINE HIGGS-SHIPMAN, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature		700 BE	LTSV	LLLE	DRI	VE B	LTSV	TLLE	, MI	20705
	St Regist	ate trar	JUN 0 8 2004		/	,							
DI	HMH 17 Rev 1/2	115	2004	-	port.	/							

			•		partment of Health and M	•	•
			1 - State Registrar		ertificate of Death	Reg. N	0001
			Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Death
	Physicia /Medic		Margaret Frances SMITH				3 2004 4:48 M
	Examin		4a. Facility Name (If not institution, give street and n		4b. City, Town, or Location of Death		4c. County of Death
			Washington County Hosp 5. Social Security Number 6. Sex		HagerStown If Under 1 Year If Under 24 Hrs.		Washington
п	Funeral Director		5. Social Security Number 6. Sex 1 M 2 12 F	7. Age (In yrs. last birthda 70 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea Feb. 25, 19	9. Birthplace (State or Foreign Country) D. C.
	D.		Usual Residence of Decedent				
	show	٦	10a. State 10b. County	10c. City, Town or			10d. Inside City Limits 1 [ZYes 2 □ No
	the M	Director	Maryland Washington 10e. Street and Number	н	agerstown 10f. Zip Code	100.0	Citizen of What Country?
	3a or	I Dir	1126 Outer Drive		21740		USA
	death	Funeral		cedent Ever in U.S. 13	B. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian,
98	or Ite	by Fu	1 Never Married 2 Married 1 Yes	2 X No live	1 ☐ Yes 2 ☑ No Specify:	1 110411, 010.7	Black, White, etc. Specify: white
Ö	tural!	q pa	3 ☐ Widowed 4 ☐ Divorced Year or 15. Decedent's Education		redent's Usual Occupation	16h	white Kind of Business/Industry
75	nin 72 n "na Medic	Completed	(Specify only highest grade completed	(Given St.)	edent's Usual Occupation ve kind of work done during most of worki . DO NOT use retired)	ng 100.	Kind of Business/industry
212	d with	Com	12 0	(1-4or 5+)	homemaker	h	er own home
nd	be filed within 72 hours after death with the Maryland tal Hygjene. d other than "natural", or Items 23a or 28a-f show event, I'm Medical Exaction or must be routified at	Be	17. Father's Name (First, Middle, Last)			(First, Middle, Maide	
Maryland 21215-0036	2 should and Men is marke aumatic	2	Francis X. Dowd 19a. Informant's Name/Relationship (Type, Print)	10h Ma		F. Rooney	
Ma	and 2 st ealth and n 27 is r		Donald A. Smith - husbar		iling Address <i>(Street and Number or Rura</i> 26 Outer Drive, Hag		· · ·
ē,	- I b =		20a. Method of Disposition	20b. Place of Dis			Location - City or Town, State
E	Pages nent of I int: If Its iry or o		1 Burial 2 □ Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify)	1 State		5/04 Ha	gerstown, Maryland
Baltimore,	permit. Departn Imports any inju		21. Signature of Funeral Service Licensee	n	22. Name and Address of Facility MII	NNICH FUNE	RAL HOME
_	20E = 9		coul //		415 E.Wilson Blvd.		
Г			23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on	each line.			Approximate Interval Between Onset and Death
	Physician /Medical			Sseminated of or as a consequence of):	Intravasion (oagulat	ion Days
ŀ	Examiner		5.	epsi >			Days
	p ==	iner	1 say leading to immediate Due to	(or as a consequence of):	.4		
	and Il-trans	Examiner	triat initiated events	o (or as a consequence of):	stridial colitis	<u> </u>	weeks
760,	te be executed ysician and e burial-transit	calE	d	, ,			
9	that the death certificate be executed ed by the attending physician and detached for use as the buriat-transit						
30X	ith cer tendir or use	an/N		utcome of pregnancy birth 2 Fetal death 3	Ectopic pregnancy		23d. Date of delivery Month Day Year
P.O. Box	the at	Physiclan/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unk		Other (specify)		Month Day Year
	The law requires that the death certifica ate has been signed by the attending phi bage 2 should be detached for use as th		Part II. Other significant conditions contributing to	death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
rds	w requires that been signed to should be deta	Completed by	Renal failure R.	espiratory t	ailure	1 🗆 Yes	2 ☐ No 3 ☐ Probably 4 ☐ Unknown
300	aw re	plete	Anemia Th	combocyte	Penia	24a. Was an	24b. Were autopsy findings available
Ĕ	The lay ate has page 2	Com	Netropenia			autopsy performed? 1 ☐ Yes 2 🗷 N	prior to completion of cause of death? 1 Yes 2 No
/ita	clan: ertific ector,	Be	25. Was case referred to medical examiner?		26. Place of Death	(Check only one)	
Division of Vital Records,	Physician: The la r this certificate has aral director, page 2	. To	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date	Inpatient 2 ER/Outpati		me 5 Residence 28d. Describe how inj	6 ☐Other (Specify)
on	Attending ir death. ector: After by the fune	tlon		nth, Day Year) Injury		Lod. Dodonbo now my	ary occurred
Visi	Atter ector by the	Certification;	3 Suicide 6 Could not be 28e. Place	ee of Injury - At home, farm, s ding, etc. (Specify)	street, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number,
۵	tal or	Cert					
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	(Check only 2 Medical Examinat: On the	basis of examination and/or	ath occurred at the time, date and place, a investigation, in my opinion, death occurre	and due to the cause(ed at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
	To the within 2. To the complet	Med	one) and ma 29b. Signature and title of certifier	nner stated.	29c. License number		Pate signed (Month, Day, Year)
	0 = 0 =		1.5	_			
,	To To		b liter w	N)	D46081		Unp III TAAL
,			30. Name and address of person who completed car	use of death (Item 23a) (Type			une 14, 2004
4			30. Name and address of person who completed car	use of death (Item 23a) (Type	e, Print)		21742
5	Sta Registr		30. Name and address of person who completed car	use of death (Item 23a) (Type			

			State of Maryland / D	epartment of Health and Menta	
			. FOI	Certificate of Death	Reg. NG 004 20354
			Decedent's Name (First, Middle, Last)	Mo	ite of Death 3. Time of Death onth Day Year
	Physicia /Medic	al	Gerald Lancolot Shank	Ju	ine 13 ZOOY OILIS am
	Examin	er	4a. Facility Name (If not institution, give street and number) Washington County Hospital	4b. City, Town, or Location of Death Hagerstown,	4c. County of Death Washington
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birts	hday) If Under 1 Year If Under 24 Hrs. 8 Da	te of Birth 9 Birthplace (State or Foreign
	Director		000 00 000 000	rs. Months Days Hours Min. (M Ma	onth, Day, Year) Country) Country)
	and *	}	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location	10d. Inside City Limits
	Maryl:	ŗo		amsport	1 ☐ Yes 2 XNo
	h the r 28a s notii	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	23a c	raiD	16432 Virginia Ave.	21795	U.S.A
	er de:	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ ▼ 2 □ No □	13. Was Decedent of Hispanic Origin? (Specify Yolf Yes, specify Cuban, Mexican, Puerto Rican,	_
036	urs af	by F	1 Never Married 2 Married 1 XYes 2 No If Yes, Give WWII 3 XWidowed 4 Divorced Year or Dates:	1 ☐ Yes 2 ☐ XNo Specify:	specify: white
21215-0036	within 72 hours after death with the Maryland ene. then "neturel", or items 23a or 28a-f show the Medical Exercites mast be notified at	Completed	15. Decedent's Education 16a. (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
121	within ane. then *	mpi	Elementary/Secondary (0-12) College (1-4or 5+) 12th grade 0	Bus Driver	Bus Company
	filed Hygir other ent, I	Be Co	17. Father's Name (First, Middle, Last)		, Middle, Maiden Sumame)
/lan		To B	Lancelotte G. Shank	Annie L.	Walburn
Maryland	E 4 2 E		19a. Informant's Name/Relationship (Type, Print) Gary Lee Shank son	Mailing Address (Street and Number or Rural Rout 5432 Virginia Ave. W	te Number, City or Town, State, Zip Code) illiamsport, MD 21795
	l an leal leal sm 2 sher			Disposition (Name of v. crematory or other place) Hill Cemetery	20c. Location - City or Town, State
Baltimore,	nit. Page partment o ortent: If injury or		4 Donation 5 Other (Specify)	HITT COMCCCTY	
Ball	permit. Pages. Department of I Importent: If ite any injury or of once.		21. Signature 21 Frail Service 11 Per 22 Service 12 Per 23 Service 12 Per 24 Service 12 Per 25 Per 2	22. Name and Address of Facility Donald Edwin Thomp P.O.BOX 310 Clear	son Funeral Home, Inc
П			23a. Part1. Enter the disease, or complications that caused the death. Do n shock, or hear failure. List only one cause on each line.	ot enter the mode of dying, such as cardiac or resp	iratory arrest, Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause Final disease or condition a	linfarction	
	Examiner		Coronary	l inferction artery disense	
	D #	ner	Sequentially list conditions, if arily, leading to intributate cause. Enter Underlying Cause (Disease or injury that initiated events	of):	
	ecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the	vf):	
760,	Physicien: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	cai E	d	·	
89	tificate ng phy as the		TESTANIS.		
Box	attending for use a	Physician/Med	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Featal death	3 Ectopic pregnancy	23d. Date of delivery Month Day Year
0.	at the dea by the a tached for	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)	
Δ.	res that the igned by be detact	by Ph	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	3e. Did tobacco use contribute to the cause of death?
rds	w require: been sig should b	ed b	Type I Diabetes Mellitus		1 ☐ Yes 2 🖟 No 3 ☐ Probably 4 ☐ Unknown
Records,	has be	Completed	Type I Diabetes Mellitus	24	4a. Was an autopsy autopsy findings available prior to completion of cause of death?
al H	icien: The certificate I		•		□Yes 2♥No 1□Yes 2□No
Vital	ysicien: The is certificate hadirector, page	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 MER/Out	26. Place of Death (Checkpatient 3 □ DOA Cther: 4 □ Nursing Home 5	ck only one)
Jot	ding Phys		27. Manner of Death 28a. Date of Injury 28b. T		escribe how injury occurred
sior	eath. or: Af the fur	catic	2 Accident investigation	M 1 □ Yes 2 □ No	
Division	for Att after d Direct I in by	Certification;	4 Homicide determined 28e. Place of Injury - At home, far building, etc. (Specify)		ocation (Street and Number or Rural Route Number, ity or Town, State)
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge 2 Medicel Exeminer: On the basis of examination and and manner stated.	death occurred at the time, date and place, and dud/or investigation, in my opinion, death occurred at t	ue to the cause(s) and manner as stated. the time, date and place, and due to the cause(s)
	To the Within To the	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
)	()		Kadu M. Vheodorn MD.	D-45563	June 13, 2004
ř	Hier.		30. Name and address of person who completed cause of death (Item 23a) (Radu M. THEODORU, MD 324 East A	Type, Print) ntietam St, Suite 203, Has	June 13, 2004 eerstown, Maryland, 21740
200	Sta Regist		31. Date filed (Month) Per Year) 5 2004 32. Registrar's Signature		
			Janes W.	Laborer .	

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Yeer **Physician** June 9, 2004 2:05 p Kenneth Henry Schmidt, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Doctor's Community Hospital Prince George's Lanham If Under 1 Year If Under 24 Hrs. 6. Sex 1 M 2 ☐ F 8. Date of Birth (Month, Day, Year, July 24, 1 9. Birthplace (State or Foreign Country) New Jersey 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Yrs. 155-16-2219 81 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Modical Examinations to motified at 1 XYes 2 No Directo Maryland Prince George's Riverdale Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5900 Taylor Road 20737 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 (X)Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Building Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be of Health and Mental item 27 Is marked o Albert Schmidt Frida Tda Bauer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria E. Schmidt - Wife 5900 Taylor Road, Riverdale Park, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 10 = 0 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or Fort Lincoln Cemetery 06/12/2004 Brentwood, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Gasch's Funeral Home, P.A. Claudette Dasch Lanning 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Coronary Artery Disease /Medical Due to (or as a consequence of) **Examiner** Dysrhythmia Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No. detached 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Xunknown Diabetes Mellitus 1 ☐ Yes 2 ☐ No Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?
Yes 2 2 No page 1□ Yes or Attending Physician: rector, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 X No Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation the 2 Accident within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 - Homicide tilled 1 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie Medicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 120K54675 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 575 Main Street, Ste. 351, Laurel, MD Shobhit Arora, M.D., 20707 31. Date filed (Month, Day, Year) JUN 1 1 2004 . Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene

				otato or maryta	Certific	ate of Death	R	eg. No.?	01.	20256
55	Physic /Medi		1. Decedent's Name (First, Middle, Las	SI	mmons		2. Date of Dear Month JUNE	th Day	Year O 4	3: Time of Death
3	Exami		4a. Facility Name (If not institution, give	e street and number)	,	4b. City, Town, o	or Location of Death	4c. Count		
			KENSINGTON NUR		AB. CENTE	R KENSIN	GTON	MONT	GOMER	Y CO.
	₀Funeral Director		5. Social Security Number 224-46-7726 Usual Residence of Decedent	7. Age (<i>In yr</i> .	Mont	der 1 Year If Under 24 H ns Days Hours Mi		Year) 1936	9. Birthplac Country VIRGI	ce (State or Foreign) INIA
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020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or items 23a or 28a-f show any fujury or other treumatic event, the Medical Evarriner must be routlied at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2. Married 1 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	If Yes, s	cedent of Hispanic Origin? pecify Cuban, Mexican, Pue 2 D No Specify:	(Specify Yes or No- orto Rican, etc.)		ce - American cck, White, etc fy: BLAC).
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Mar	12 sh h and ' Is m treum		19a. Informant's Name/Relationship (T)			ess (Street and Number or F				nde)
e,	1 and Healt em 2	1 8	DELORES FULLER 20a. Method of Disposition		Place of Disposition ()	HELEN DRIVE	, ACCOK	EEK, N	ID 2 City or Town	20607
Baltimore,	t. Pages tment of tant: If it tant: or o		1 X Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)) M1		CEMETERY	6-11-04			
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Š	af or Attend s after death If Director: /	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, street, factorify)	ory, office	28f. Location (Stre City or Town,		er or Rural Ro	ute Number,
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State of Maryland / Department of Health and Mental Hygiene

				State of Mary		<i>Certificate</i>				leg. No.?	01. 2	00357
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	and w	-	Usual Residence of Decedent 10a. Stete 10b. County	10	c. City, Town o	r Location					10d.	Inside City Limits
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	1 and 3 Health em 27 i		Thomas J. Jenkins/					. Hyatts				
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R	(6)		30. Name end eddress of person who co	mpleted cause of deeth	(Item 23a) (Ty	pe, Print)	10	Bran	dley	BC	rel 1.	Selfe sol q
	State	9	31. Dete filed (Month, Day, Year)	. Registrer's	Signature						MD	20817

			1 - For State Registrar	State of Maryland / Dep	partment of Health and ertificate of Death	Mental Hygie	
	/		1. Decedent's Name (First, Middle, Last))		2. Date of Death	3. Time of Death
	Physici /Medio		Robert Smit	h Sanders		June	Day 6, 2004 1053 PM
}	Examir		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Dec	ath	4c. County of Death
			Doctor's Hospi		Lanham		Prince George's
	Funeral Director		5. Social Security Number 6. Security Number 185-24-7612	X 7. Age (In yrs. last birthda) Yrs. 73 Yrs.	Months Days Hours Min		9. Birthplace (State or Foreign Country)
			Usual Residence of Decedent	1 /3		Mar.9,	1931 Pennsylvania
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	or 28	Jire	10e. Street and Number		10f. Zip Code	10g	. Citizen of What Country?
	ath w	ral	12502 Sir Walt		20769		USA
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21215-0036	within 72 hours after death with the Maryland ene. than "netural", or Itams 23a or 28e-f show Ita Madical Examiner must be notified at	ted	15. Decedent's Educ	cation 16a Dec	edent's Usual Occupation	16	b. Kind of Business/Industry
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	1 and Healt am 2		Jane O. Sanders 20a. Method of Disposition	s / spouse 1250	2 Sir Walter D		n Dale, MD. 20769
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₹	artme orten injur		 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licentee 	Metropo	olitan Crem. 6-6 22. Name and Address of Facility	0-2004 A1	exandria, VA.
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			23a. Part1. Enter the disease, or compli	cations that caused the death. Do not en			Approximate
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/	5 11		18Acy Co.ma		D 42580		3-7-04
-(/	4) IVa	1	30. Name and address of person who cor	mpleted cause of death (Item 23a) (Type.	Print)	2 Binni	NSBURG, MD 20710.
			31. Date filed (Month, Day, Year)	#32 Registrar's Signature		3 10000100	123/84/207
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DHMH 17 Rev 1/2001

Sanders, Robert Smith Sk.

should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** JIBRIL MUHAMMAD SHELBY 30 2004 May 2:20 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 2205 Ritchie Road Capitol Heights Prince George's If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 11 - 24 - 1984 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral 1**X** M 2□F Months Days Hours Min 218-08-4612 19 WASHINGTON, DC Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director PRINCE GEORGES UPPER MARLBORO 10e. Street and Number 10g. Citizen of What Country? 20774 U.S.A. Items 23a 10722 CASTLETON WAY Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married õ 1 ☐ Yes 2X No Specify: BLACK Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) STUDENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental H FILSAIME PHYLLIS SHELBY REGINALD W. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 10722 CASTLETON WAY, UPPER MARLBORO, MD PHYLLIS ALEXIS - MOTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Pages 1 ment of P tent; If ite ō Department of Importent: If any injury or once. 4 □ Donation 5 □ Other (Specify) GLENWOOD CEMETERY 6-7-04 WASHINGTON, DC 21. Signature of Funeral Service ti 22. Name and Address of Facility TAYLOR'S FUNERAL HOME 1722 NORTH CAPITOL ST., NW WASH.DC 20001 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Physician/Medical Examiner the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

X Yes 2 No 24a. Was an director, page 2 s 1 X Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: $_{4\,\square}$ Nursing Home $_{5\,\square}$ Residence $_{6\,\square}$ Other (Specify) at scene 2 1X Yes 2 □ No 2 ER/Outpatient 3□ DOA 27. Manner of Death 28b. Time of Injury, Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural 30 2 Accident
3 Suicide Diractor: Location (Street and Number or Rural Route Number, City or Town State) 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.



or Attending Physicien: The law requires that the death certificate be executed

P.O.

Division of Vital Records.



the within To the

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Laron Locke M.D. 31. Date filed (Month, Day, Year) State

JUN 0 7 2004



111 Penn Street, Baltimore, Maryland 21201

Registrar

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

May 30, 2004

Eloise C.Spann 04-03926 RPD

unpend item#23a,27,PER ME,C833,7/8/.04eg
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

) _			1 - For State Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment of F		Mental Hy	giene Reg. Næ. () (- Canada	20360
	Physici /Medi		1. Decedent's Name (First, Middle, La Eloise C. Spann	st)				2. Date of De June	14, Day 200	4 Year	3. Time of Death 11:27 AM
	Examir		4a. Facility Name (If not institution, given Laurel Regional	,		4b. City, Town, o Laurel	r Location of Deatl	h	4c. County Prin		eorge's
	Funeral Director		250-40-6574	ex 7. Age □M 2¶2 F	(In yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of 8i (Month, D. 01 27	av. Year)	9. Birth Cou Dill	place (State or Foreign ntry) on, S.C.
7	anyland ehow	5	Usual Residence of Decedent 10a. State 10b. County S.C.		10c. City, Town or Lo						10d. Inside City Limits ★□ Yes 2 □ No
	n the N r 28a-f	irecto	10e. Street and Number		Lancasc	10f. Zip Code			10g. Citizen of	What Cou	
	23s c	ralD	817 Clinton Avenu	e Extensio	n	29720			USA	1	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Iteme 23a or 28a-f show any Injury or other traumatic event. I're Modical Examinar must be notified at once.	by Funeral Director	11. Marital Status 1 Xever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 23 No	ispanic Origin? (S in, Mexican, Puert Specify:	pecity Yes or No o Rican, etc.)		ce - Americk, White,	
21215-0036	ithin 72 ho ne. nan "natu	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5+	(Give	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of wor f)	king	16b. Kind of B	usiness/In	dustry
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lary	2 should and Men Is marka	-	19a. Informant's Name/Relationship (Type, Print)		ng Address (Street	and Number or Ru	ral Route Numb			Code)
	1 and Health em 27 thar tr		Samuel Spann III, 20a. Method of Disposition	Son	12900 20b. Place of Dispo	River Ri	dge Pl.	Laurel,			
nor	Pages nent of I int: If its		1 ☐ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specific		Lancaste	natory or other plac			20c. Location -		
Baltimore,	permit. P Departm Importar any Injur		21. Signature of Funeral Service Licen		22	. Name and Addres	s of Facility Ma	rshall'	s Funera	1 Ho	me
Mary Service	/Medical Examiner	Examiner	23a. Part Venter the disease, or composition, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events	a. Due to (or as a	he death. Do not ent b. Stroenteriti consequence of): consequence of):		g, such as cardiac	or respiratory a	rrest,		Approximate Interval Batween Onset and Death
Box 68760,	The law requires that the death certificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical Exa	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	Due to (or as a d. 23c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Dai	e of delive	ery Day Year
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Division	F in F	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	y - At home, farm, stre (Specify)	eet, factory, office		28f. Location (S City or Tox	Street and Number vn, State)	er or Rura	l Route Number,
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	To T Com	Σ	29b. Signature and title of certifier			29c. License			29d. Date signed		
,			30. Name and address of person who o	completed cause of dea	th (Item 23a) (Type I	O.C.M	I • C •		June 15	, 201	J 4
_	0		AND RW		111	Penn Str	eet, Bal	timore,	Marylan	d 21	201
	Sta Registr		31. Date filed (Month, Day, Year) JUN 1 8 2004		s Signature	les .					

DHMH 17 Rev 1/2001

			1 - For State Registrar		aryland / De	partmen e <i>rtificat</i>			nd M		giene leg. No.	004	20361
	Physic /Medi		Decedent's Name (First, Middle, La	Mary H.	Savage					2. Date of Dea Month June	th 16	2004	3. Time of Death 9:00 A M
	Exami		4a. Facility Name (If not institution, given 5330 Dorsey Hall	Drive		El.	lico	Location of Lt Cit	-y		F	ounty of Death Howard	
	Funeral Director		7	Sex 7. Ag 1 □ M 2K F 9	e (In yrs. last birthda 4 Yrs.	y) If Under Months	Days	If Under 2 Hours	4 Hrs. Min.	8. Date of Birth (Month, Day) 12–10–	, Year)	9. Birthp Coun Mass	lace (State or Foreign stry) Sachusetts
	e Maryland ta-f show	ctor	10a. State 10b. County MA Worcest	ter	10c. City, Town or Leominst							11	0d. Inside City Limits 1 ☐ Yes 2 No
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9600	filed within 72 hours after death with the Maryland Hygiene. thar than "naturel", or tlems 23a or 28a-f show int, the Madical Exacting trust be notified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 [X] If Yes, Give Year or Dates:		3. Was Deced If Yes, spec			in? (Spe Puerto i	cify Yes or No- Rican, etc.)		. Race - Americ Black, White, o pecify: Wh	
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Maryland 21215-0036	tai do do	To Be Co	17. Father's Name (First, Middle, Last Ambrose Doyle	')		TOTTETTAL	ær	18. Mother		(First, Middle, I		Wn Home	
, Mary	nd 2 shoulth and 27 is m		19a. Informant's Name/Relationship Peter J. Savage/Sc		19b. Ma 1019	iling Address 00 Max	(Street a	nd Number St. El	or Rura lic	Route Number	City or 7	own, State, Zip 21042	Code)
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<u>(</u> 5)	03		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type 9051 BAL	o, Print)	e N	HIL F	ike	HAC	EL	MICTO	21042 cm mp
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			For State Registrar	State of	Maryland		artment rtificate					giene Reg. No.	2001	20362
			1. Decedent's Name (First, Middle, Las	st)							2. Date of Dea Month	ath Day	Year	3. Time of Death
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	Funeral		5. Social Security Number 6. S		Age (In yrs. la		If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Day	y, Year)		nplace (State or Foreign untry)
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	ow ow		10a. State 10b. County		10c. City	, Town or Lo	ocation							10d. Inside City Limits
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	er de	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Deceded	es?	5. 13.	If Yes, spec	of Cuba	n, Mexicar	n, Puerto	ecify Yes or No- Rican, etc.)		Black, White	e, etc.
336	al', or	þ	3 Widowed 4 Divorced	If Yes, Give Year or Date			1 ☐ Yes	2 ∑ No	Specify:			,	Specity: Wh	ite
21215-0036	within 72 hours after death with the Maryland ane. than "natural", or Items 23a or 28a-1 show the Medical Examinar must be notified at	Completed	15. Decedent's E. (Specify only highest gra	ducation de completed)		16a. Dece	dent's Usua kind of wor	al Occupa	ition luring mos	t of worki	ing	16b. Kin	nd of Business/	Industry
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	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla ariment of Health and Mental Hyglene. ariment of Health and Mental Hyglene. orient: If item 27 is marked other than "natural", or Items 23a or 28a-1 show injury or other traumatic event, the Medical Examinat must be notified at an injury or other traumatic event, the Medical Examinat must be notified at 8.		Linda Wells (Dat	ıghter)		Name of the last			-		wie, Ma			
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Bail	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Sorvice Lieu	/ 11/										ert, P.A. MD 20736
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of V	Physician: this certific ral director.	2	1 ☐ Yes 2 ☑ No		patient 2 1	i			4 <u>A</u> NI		me 5 Resid			cify)
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	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	cal	29a. Certifier 1 Certifying P	hysician: To the b	pest of my know	wledge, dea	th occurred	at the tim	ne, date ar	nd place,	and due to the	cause(s)	and manner as	stated.
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	Vitto Con	Σ	29b. Signature and title of certifier	Lhi	ull	1							ne 14,	
			30. Name and address of person who	completed cause	of deathern	23a) (Tune		5928	94			ou.	110 11,	
	5		Shid Shamim, M.I					Silv	er S	pring	g, Mary	land	20902	
	SI	tate	31. Date filed (Month, Day, Year)		gistra s Signa	iture	do							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Year **Physician** 3:15 AM murtle 2004 JUNE /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Genesis ElderCare Severna Park Anne Arundel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months Days Hours 1 □ M 2 1 F 95 Yrs Director 081-14-6231 May 31, 1909 Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland neat of Health and Mental hygiene.
ant: if tem 27 is merked other than "naturel", or items 23s or 28s-f show ury or other transmit be notified at ury or other traumatic event, the Medical Exertime matt be notified at ury or other traumatic event, the Medical Exertime matt be notified at 10h County 10c. City, Town or Location 10d. Inside City Limits 10a. State Anne Arundel MD Glen Burnie 1 ☐ Yes 2 X No **Funeral Director** 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 2712 Robin Road 21060 USA Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 1 Married White Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: þ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondary (0-12) Waitress 8 Restaurant 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Lest) William Dewire Jennie Litterer 19b. Mailing Address (Street and Number or Rurel Route Number, Cify or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Edwin W. Smith/Husband 2712 Robin Road, Glen Burnie, MD 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jun. 10 Metro Crematory Baltimore, MD 2004 21. Signal of Fineral Service Licensee 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 23a. Pert? Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical · Congressive Heart 2645 Examiner Physician/Medical Examiner Hypertensul typerosaleutre Curlio varalar Diseun sician and burial-trensit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of) page 2 should be detached for use es 23b. Did tobacco use contribute to the cause of death? Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 2 X No 3 Probably 4 Unknown 1 Tes Anemic Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 27. Menoer of Deeth 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No s efter death. investigation 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rurel Route Number, City or Town, State) 4 I Homicide To the Hospital o within 24 hours of To the Funeral Di completely filled in 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, end due to the ceuse(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29d. Date signed (Month, Day, Yeer) 29c. License number 29b. Signature and title of certifier D 396660 June 10, 2004 horut Drut 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)

State

Registrar

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2004

Robert Durt

JUN 14

31. Dete filed (Month, Day, Year)

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FUCT

32. Registrer's Signeture

Baltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** 10:20 PM June 11 2004 Elise DuBois Seymour /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Ginger Cove Health Center Annapolis If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months 1 M 2 X F 90 9/27/1913 150-12-3985 Pennsylvania Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "netural", or Items 23a or 28a-f show Annapolis 1 ☐ Yes 2XXVIo Maryland Anne Arundel Director the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21401 U.S.A. 4000 River Crescent Drive Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be fited within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2XXIIo Baltimore, Maryland 21215-0036 1 ☐ Yes 2ĈXNo Specify. Specify: White Completed by 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 7 is marked other than treumatic event, the W. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Arthur Wood DuBois Rena Merrell ပ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3425 N. Randolph St. Arlington, VA Jack Seymour/son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of H
Important: If ite
any injury or of 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 6/15/2004 Baltimore, MD Baltimore Crematory 4 Donation 5 Other (Specify) 21. Signal Funeral Prvi License 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** EMENTIA /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (ite as a consequence of) physician and the burial-transit the Hospitel or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 1 Yes 2 5 N 1 Yes 2 No filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ZNo 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death after death. Director: After t 1 Accident Injury 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a

To the Funerel C

completely filled i NG Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 6-14-04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. William Dabbs 277 Peninsula Farm Road Arnold, MD 21012 32 Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 1 5 2004 Registrar

ORIGINAL

			For State	State of Maryland / D	ер		Health and		gien	5nni	20365
			1. Decedent's Name (First, Middle, Last)			rimoate of	Death	2. Date of D	Reg. N	0% 00 0	3. Time of Death
	Physici /Medic		Mary Lou Stockett			1		June 1	3, 2	2004 Year	1300 ^M
	Examin	er	4a. Fecility Name (If not institution, give				or Location of De	eath	44	c. County of Deat	h
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ĺ,	Funeral Director		5. Social Security Number 6. Security Number 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	THE OFFICE	hday) (rs.	Months Days			ay, Year		nplace (State or Foreign untry) rvland
	p		Usual Residence of Decedent								
	rylar thow		10a. State 10b. County	10c. City, Town							10d. Inside City Limits
	Ba-f.	Director	Maryland Anne Ar	undel Glen H	dur	nie					1 Yes Z
	or 24	Sire	10e. Street and Number			10f. Zip Code			10g. C	itizen of What Co	untry?
	23a	a	361 Gaylor Road			2106	0		Uni	ited Star	tes
	ep .	ne l	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13.	Was Decedent of I	Hispanic Origin?	(Specify Yes or Ne erto Rican, etc.)	o-	14. Race - Amer Black, White	
36	rs afte	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:)	1 ☐ Yes 2 ♠No		, , , , , , , , , , , , , , , , , , , ,			nite
21215-0036	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hyglene. artment of Health and Mental Hyglene. ordrant: if Item 27 is marked other than "natural; or Items 23a or 28a-f show injury or other traumatic avent, the Madical Examination and injury or other traumatic avent, the Madical Examination and injury or other traumatic avent, the Madical Examination and injury or other traumatic avent.		15. Decedent's Edu (Specify only highest grade	cation 16a. t		dent's Usual Occu		vodkina	16b.	Kind of Business/l	ndustry
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<u> </u>	should ind Men in marke	^L	19a, Informant's Name/Relationship (Tv.		Maili	no Address (Street		Rural Route Numb		-	in Code)
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ē,	Hea tem other		20a. Method of Disposition	20b. Place of I	Dispo	sition /Name of	Ī	Date	_	ocation - City or 1	Fown, State
20	Pages nent of int: If It iny or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State Baltin	or	e Cremate	őry Jun	e 18, 20	04 E	Baltimore	e, MD
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service License	e							1 Home, Inc.
_	40 F # 9	L. 23	J. Scott	Konsandy	1	47 Duke	of Glouc	ester St	. An	napolis,	MD 21401
	Physician /Medical Examiner		23a. Pert1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ications that caused the death. Do not not cause on each line. Due to (or as a consequence of	ti	•				_ \	Approximate Interval Between Onset and Death
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P.O. Box 6	the death certificate y the attending phy. iched for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 → No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown		Ectopic pregnanc Other (specify)	у			23d. Date of delin Month	very Day Year
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g	ificat or, pi	Ö	25. Was case referred to medical				00 Bi(B	1 Yes	2 X No	1 Yes	2 No
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			Hung Davis M.D.	2003 Medical Parkway	/	nnapolis	MD 2140	01 D5311			
	Sta Registra		31. Date filed (Month, gly Near) 5	2004 ^{32. Reg Strar's Signature}		Small ,					

TA	L. SHI	RES	THA 1 - For Stata 6 - 17 - 04 Registrar Amend # 10 f . 1	State of Mary	0-		Health a	and Menta	al Hygie	•	20366
	* **	1	Decedent's Name (First, Middle, Las.)		3\L				te of Death	Day Year	3. Time of Death
4	Physici /Medic		Anita L. Shresth	na						2004	10:30 P ^M
>	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town	, or Location o	of Death		4c. County of De	ath
			10901 MOUNT LUE	BENTIA WAY		UPPER	MARLEC			PRINCE (GEORGES
	Funeral Director		298-38-2520	7. Age (In	yrs. last birthday, Yrs.	Months Day		24 Hrs. 8. Dat Min. (Mo June	le of Birth onth, Day, Ye 2 16,	9. B 1944 C1	irthplace (State or Foreign Country) eveland, OH
	and and		Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or L	ocation					10d. Inside City Limits
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	288-	Director	10e. Street and Number			10f. Zip Code	9		10g.	Citizen of What (Country?
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	ms 2	Funeral	11. Marital Status	12. Was Decedent Ever	in U.S. 13.	Was Decedent of If Yes, specify C	f Hispanic Orig	gin? (Specify Ye	s or No-	14. Race - An	
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, Maryland 21215-0036	permit. Pages 1 and 2 should by Department of Heatils and Menta Importent: If item 27 is marked eny injury or other treumatic e <u>once</u> .		19a. Informant's Name/Relationship (T	ha	1168	4 Ventur	a Blvd			y or Town, State lio City	Zip Code) . Ca. 91604
Baltimore,	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	Ob. Place of Disp cemetery, cre	osition (Name of matory or other p	olace)	Date	20c	Location - City of	or Town, State
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	ficate p phy s the			. v.							
Box	death certificat e attending phy id for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pr		¬				23d. Date of d	alivery
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Division of Vital Records,	s been si should	Completed						24	a. Was an	24b. Were	autopsy findings available
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5	Physicien: The I this certificate har ral director, page	To Be	examiner?	Hospital: 1 ☐ Inpatient	2 ER/Outpatie	nt 3 DOA				6 XOther (Sp	ecify) AT SCENE
ō	g Phy er this	Ë	27. Manner of Death	28a. Date of Injury	28b. Time o		jury at			jury occurred	00.17)
0	ding th.	100	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yea	ar) Injury		vork? ∐Yes 2.∏i	No			
<u> S</u>	or Attending after death. Director: After in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	280. Place of injury	At home, farm, st	reet, factory, offic	Ce Ce	28f. Loc	cation (Street	and Number or F	Rural Route Number,
á	afte Dir	ert	4 🗀 Homicide	building, etc. (S	овспу)			City	y or Town, St	a10)	
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical C	29a. Certifier 1 Certifying Phyone) Check only one)	ysician: To the best of my niner: On the basis of exa- and manner stated.	/ knowledge, dea mination and/or ir	th occurred at the ovestigation, in m	time, date and y opinion, deat	d place, and due th occurred at th	e to the cause te time, date	e(s) and manner a and place, and du	as stated. le to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of ontifier	1 11	,	29c. Lice	nse number		29d.	Date signed (Mor	
	->			NI.		0	.C.M.E		ange of Admin	JUNE 7	, 2004
	(5)		30. Name and address of person who d	completed cause of death	(Item 23a) (Type	Print)	· · · · · · · · · · · · · · · · · · ·				
,			TAKE M. Tike	s M.D.			et, Bal	ltimore.	Mary]	and 212	01
	Sta	te	31. Date filod (Month, Day, Year)	D Registrar's S	Signature			•			
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Usual Residence of Decedent 10a. State 10b. County VIRGINIA FAIRFAX 10e. Street and Number 7318 SCARLET OAK C.	Street and number) HOME T. T. T. Age (iiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii	81 Yrs. Oc. City, Town or Lo FAIRFAX S or in U.S. 13.	Ab. City, Town, o ROCKV If Under 1 Year Months Days cation FATION 10f. Zip Code 2203 Was Decedent of H 1 Yes, specify Cube tin Yes 2 No dent's Usual Docup kind of work done DO NOT use retired	or Location of Death VILLE If Under 24 Hrs. Hours Min. 49 dispanic Drigin? (Span, Mexican, Puerto Specify:	2. Date of Death Month JUNE 1, 8. Date of Birth 5 (Month, Day, 7 MAY 10,	Day Year 2 004 4c. County of Deet MONTGOME; 1 1923 Birth Policy POLA Citizen of What Co U.S.A. 14. Race - Ame Black, White	RY hplece (State or Foreig untry) AND 10d. Inside City Limits 1 \(\bar{N} \) Yes 2 \(\bar{N} \) No untry?
4a. Fecility Name (If not institution, give: ROCKVILLE NURSING 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Septimized Security Number 7. State 10b. County VIRGINIA FAIRFAX 10e. Street and Number 7. Street and Number 7. Street and Number 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) NOAH 19a. Informant's Name Relationship (Ty	T. 12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give year or Dates: 1 College (1-4or 5+) 4 BISE	81 Yrs. Oc. City, Town or Lo FAIRFAX S. ar in U.S. 13. 1 16a. Deceding life.	ROCKV If Under 1 Year Months Days cation FATION 10f. Zip Code 2203 Was Decedent of H 1 Yes, specify Cube the Second of the Code of	If Under 24 Hrs. Hours Min. 49 dispanic Drigin? (Span, Mexican, Puerto Specify:	8. Date of Birth 5 (Month, Day, 10) 100 ecify Yes or No-Rican, etc.)	4c. County of Deet MONTGOME; 1-1923 Birth ear) POLA Citizen of What Co U.S.A. 14. Race - Ame Black, White	h RY hplece (State or Foreig untry) 10d. Inside City Limits 1 ☑ Yes 2 ☐ No untry? rican Indian, e, etc.
ROCKVILLE NURSING 5. Social Security Number 579-20-3654 Usual Residence of Decedent 10a. State 10b. County VIRGINIA FAIRFAX 10e. Street and Number 7318 SCARLET OAK CT 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grade (Specify only high	T. 12. Was Decedent Ever Armed Forces? 1 Tyes 2 M No 1 Yes, Give Year or Dates: 12. Was Decedent Ever Armed Forces? 1 Tyes 2 M No 1 Yes, Give Year or Dates: 12. Was Decedent Ever Armed Forces? 2 1 Tyes 2 M No 1 Yes 2 M No 1 Yes 2 M No 1 Yes Year or Dates: 13. College (1-4or 5+) 4 BISE	81 Yrs. Oc. City, Town or Lo FAIRFAX S. ar in U.S. 13. 1 16a. Deceding life.	ROCKV If Under 1 Year Months Days cation FATION 10f. Zip Code 2203 Was Decedent of H 1 Yes, specify Cube the Second of the Code of	If Under 24 Hrs. Hours Min. 49 dispanic Drigin? (Span, Mexican, Puerto Specify:	MAY 10,	MONTGOME: 1-1923 Birtle 1923 POLA Citizen of What Co U.S.A. 18. Race - Ame Black, White	RY hplece (State or Foreignanty) 10d. Inside City Limits 1 2 Yes 2 No untry? rican Indian, e, etc.
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NOAH 19a. Informant's Name/Rejetionship (Ty STERN			11/11/		(OWN HOME	
19a. Informant's Name/Relationship (Ty. STERN				18. Mother's Name	e (First, Middle, Ma	iden Sumame)	
		KAR		MOLLIE		TREST	
NEIL M. STERM /SON	γρe, Print)	19b. Mailir	ng Address (Street	and Number or Rura	al Route Number, (City or Town, State, Z	ïp Code)
CO. Mathed of Disconting							
1 X Burial 2 ☐ Cremation 3 ☐ R	Removal from State	cemetery, crer	natory or other place	ce)		· · · · · · · · · · · · · · · · · · ·	
					/2004 FA	ALLS CHURC	H, VA
Tornald.	1 de mar	I	ANZANSKY	-GOLDBERG	MEMORIAI KE, ROCKV	CHAPELS,	INC. 20852
23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	lications that caused the ne cause on each line.	e dath. Do not ent	er the mode of dyin	ng, such as cardiac o	or respiratory arrest	t,	Approximate Interval Between
Immediate Cause (Final disease or condition	HYPERTENS	SIVE HEAR!	C DISEASE				Onset and Death
resulting in death)	Due to (or as a c	onsequence of):					
Sequentially list conditions,	0						
cause. Enter Underlying Cause (Disease or injury		orresqueries ory.					
that initiated events resulting in death) Last	U	onsequence of):					
	d						
	u						
IF FEMALE: 23b. Was decedent pregnant			Tatania anno an			23d. Date of deli-	very
in the past 12 months? 1 \(\subseteq \text{Yes} 2 \subseteq \text{No} \)	4 Pregnant at tim			·		Month	Day Year
						1	
Part II. Other significant conditions cor PLEURAL EFFUSION	ntributing to death but r	not resulting in the u	nderlying cause giv	en in Part I.			
					24a. Was an	24b. Were aut	topsy findings available completion of cause of
					performe	d? death?	2 No
25. Was case referred to medical							
1 ☐ Yes 2 📉 No	Hospital: 1 ☐ Inpatient	2 ER/Outpatien			me 5 Residence	ce 6 Dther (Spec	ify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y		Wor	k?	28d. Describe how	injury occurred	
2 Accident investigation							
4 Homicide determined	28e. Place of Injury building, etc. (At home, farm, str Specify) 	eet, factory, office				ral Route Number,
29a. Certifier 1 💢 Certifying Phys. (Check only 2 Medical Exami	sicien: To the best of n	ny knowledge, death	n occurred at the tim	ne, date and place,	and due to the caus	se(s) and manner as	stated.
one)	and manner stated	i.					
	11 6)					
			5173	30		JUNE 2, 20	04
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			A		, MAKILAN	ע עעט ע	
]	NEIL M. STERM/SON 20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions con PLEURAL EFFUSION 25. Was case referred to medical examiner? 1 Yes 2 No 27. Magner of Death 1 Onatural Sepending Investigation Sequence of Could not be determined 29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Name and address of person who could be determined	NEIL M. STERM/SON 20a. Method of Disposition 1	NEIL M. STERM/SON 20a. Method of Disposition 1	NEIL M. STERM/SON 7318 SCARLET 20a. Method of Disposition 20 20b. Place of Disposition 20 20b. Place of Disposition 20b. Place	NEIL M. CTERM SON 7318 SCARLET DAK CT.	NETL M. STERM/SON 7318 SCARLET OAK CT. FAIRFAX 200 Method of Disposition 1	Temperature Temperature

	1	- State Registrar Amend#5per	State of M								leg. Nd.			200	C 0
		1. Decedent's Name (First, Middle, La							2	2. Date of Dea	ith Day		ear	3. Time o	
hysician /Medical		David Gary Shera	ey							June	3			2:2	SAM
xaminer	•	4a. Facility Name (If not institution, gi	e street and number	er)		4b. City,	Town, or	Location of	Death		4c.	County of I	Death		
		Kline Hospice Ho						Airy	4 Uen e			Frede			
neral ector		215-74-2337	1 ⊠ M 2□F	41	last birthday) Yrs.	Months	r 1 Year Days	If Under 24 Hours	Min.	B. Date of Birtl (Month, Day Jan 26	196	3 W		ace (State ry) ingto	
2	-	Usual Residence of Decedent 21 10a. State 10b. County	5-74-2339		ty, Town or Lo	cation							10	d. Inside C	ity Limits
tien z. I is marked other than natural, or tens z.s or zeer enow other treumstic event, its Mudical Express; must be notified at To Re Completed by Funeral Director		MD Freder	ick		unswic										2 No
be notified	2	10e. Street and Number				10f. Zir	Code		· -		10g. Citi	zen of Wha	t Count	ry?	
The second		620 6th Avenue				2	21716	,)			U	SA			
Funera	-	11. Marital Status	12. Was Decede Armed Force		J.S. 13.	Was Dece	dent of Hi	spanic Origi n, Mexican,	n? (Spec	ify Yes or No-		14. Race -			
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d by	2	3 Widowed 4 Divorced	Year or Date	s:	1										
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Tu C		17. Father's Name (First, Middle, Las	t)		1			18. Mother	s Name (First, Middle,	Maiden	Sumame)			
To Be	0	William Otto She	erzey, Sr					Alic	e Isa	abel Yo	ung				
the L		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address	s (Street a	and Number	or Rural	Route Numbe	r, City o	r Town, Sta	ite, Zip	Code)	
er tre	27	William O. Shera	zey, Jr.,	Broth	ier 28	10 Da	avis	Avenu	e, A.	Lexandı	ia,	VA 2	2302	2	
t d		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3	Bemoval from Sta		Place of Dispo cemetery, crei	matory or o	other place	θ)	Da			cation - Cit			
uryo		'4 □ Donation /5 □ Other (Spec		Hag	gerstov	vn Cr	emato	ory 6	/4/0	4	Hage	rstow	m,]	MD	
important: it tient of its marked other than eny injury or other treumatic event, ILIAN DOES. TO Re COMP		21. Signature of Funeral Service Lice Darbara A. Wi	Illiams, (ymer Owner	J	ohn T	r. Wi	s of Facility 11iams ville	s Fur Road	neral H	lome Iswi	ck, M	D 21	716	
ician dical niner		23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. And	n line.	APCIN									Approxima Interval Be Onset and	tween
s the burial-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a consec as a consec											
use as	Idn/me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcor 1□Live birth 4□Pregnant	2 Feta	al death 3[]Ectopic p] Other (s;					0.4	23d. Date o Month		-	Year
detached for	ysic	1 □ Yes 2 ☒ No 9 □ Unknown	9☐ Unknow		364.11		Jociny)								
		Part II. Dther significant conditions	contributing to deat	h but not res	sulting in the u	nderlying o	cause give	en in Part I.		23e. Did to		se contribu	te to the		death? Unknown
should	eie									24a. Was	an	24b. Wer	e auton	sy findings	available
ge 2	Ĕ.									autop perior	sy med? 223 No	deat	th?	sy findings	cause of
rector, pag	3	25. Was case referred to medical	+					26 Place o	of Death /	1 ☐ Yes Check only o		10	Yes	2 NO	
direct	0	examiner? 1 Yes 2 No	Hospital:	atient 2] ER/Outpatier	nt 3 🗆 Do	OA Othe	D.F.		e 5 Resid		Other (Specify	11651	CE
funeral di	T LOD	27. Manner of Death 1 Natural 5 Pending	28a. Date of I (Month,		28b. Time o Injury		28c. Injury Work	at	28	ld. Describe h		-			10456
to the Funerel Director: Affer this Certificate has completely filled in by the funeral director, page 2 Madical Certification: To Be Comp	ertifica	2 Accident investigation 3 Suicide 6 Could not determine	be 28e. Place of	Injury - At h etc. (Speci	lome, farm, str fy)		y, office		28	If. Location (S City or Tow	itreet an n, State	d Number (or Rural	Route Nun	nber,
e Funere letely fille	edical		nysician. To the basis aminer: On the basis and manner	s of examina											s)
ro th comp	Me	29b. Signature and title of certifier	, Illaa	يخر	MD	29	c. License		75			e signed (A			4
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4	1	30. Namerand address of person who	completed cau	death (Ite	m 23a) (Type,		A 37.0	110 D-	run a-	vick, M	LD 3.	1716			

		_ For	State of Ma	ryland / Dep	artment of	Health and	Mental Hyg	iene		
		1 - State Registrar		Ce	rtificate of	Death	R	eg. No.	004	20369
Physic	an	1. Decedent's Name (First, Middle, Last	1)				2. Date of Dea Month	th Day	Year	3. Time of Death
/Medi Exami	cal	Bonnielu Thompson 4a. Facility Name (If not institution, give			4b. City, Town,	or Location of Dea	TUNE	40.	County of Dea	•
LAAIIIII	ici	Washington County	v Hospital		Hage	rstown		Wa	shinata	on County
Funeral		5. Social Security Number 6. Se	x 7. Age	(In yrs. last birthday)		r If Under 24 Hrs		Year)	9. Bir	thplace (State or Fore
Director		5/9-50-9642	□M 21XF	87 Yrs.	I Day	10010	October	27,	1916 Te	ennessee
*	1	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation					10d. Inside City Lim
a 23a or 28a-f show	5			T 2 L L 1	0.1				3	1 □ Yes X□N
288-	Director	Maryland Allegher 10e. Street and Number	ny	TITELE	Orleans	3		0a. Citi:	zen of What Co	ountry?
a or		12509 Swain Rd. I	V E		2170	56				
itama 2:	Funeral	11. Marital Status	12. Was Decedent E	ver in U.S. 13.		Hispanic Origin? (Suban, Mexican, Pue	Specify Yes or No-		S.A. 14. Race - Ame	
100	귤	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 📉 No		1 ☐ Yes 2X N		to Hican, etc.)		Black, White	
10.00	d by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		TILI TOS ZALINO	о Ѕреспу:			Specify:Whi	.te
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than the Me	ldμ	Elementary/Secondary (0-12)	College (1-4or 5+	•)	DO NOT use retir	,			_	
1 Page 1		17. Father's Name (First, Middle, Last)		<u> </u>	Homemake:		me (First, Middle,			Residenc
9 th th) Be	Robert F. Cato					aret Ann		,	
th and Menta	L L	19a. Informant's Name/Relationship (T	ype, Print)	19b. Maili	ing Address (Stree	et and Number or R			Town, State, .	Zip Code)
8 2 8		Brenda L. Engel	(Daughter)	125	509 Swaii	n Rd. N.E	. Little	Orl	eans. N	aryland 2
f Health Item 27 other tr		20a. Method of Disposition		20b. Place of Disp	osition (Name of matory or other p		Date	20c. Lo	cation - City or	Town, State
		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State)	1		.	e 7. 04	Smi	thsburg	, Marylan
Department Ingo Department Important: I any injury o		21. Signature of Funeral Service Licens			2. Name and Add					eral Home
19 = 9		Duck A	Line	1	1331 East	tern Blvď	. N. Hage	rst	own, Ma	ryland 21
		23a. Part1. Enter the disease, or comp shock, or head failure. List only of	olications that caused tone cause on each line	the death. Do not en	ter the mode of dy	ying, such as cardia	c or respiratory arr	est,		Approximate Interval Between
nysician	8 9	Immediate Cause (Final disease or condition	Care	ha van	aren .	Accident				Onset and Death
/Medical		resulting in death)	Due to (or as a	consequence of):						
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s is	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter of course (Disease or injury that initiated events	Due to (or as a	consequence of):						
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ins raw requires in a me death certained to the attending phypage 2 should be detached for use as the	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of					2	3d. Date of de	livery
atter	iclar	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at t		⊒Ectopic pregnan ⊒ Other (specify)	icy		- 1	Month	Day Year
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as be 2 sh	Completed						24a. Was a autops		24b. Were at	utopsy findings availa
	Con						perfòri 1 ☐ Yes	ned/	death?	2□ No
this certificate	Be (25. Was case referred to medical examiner?					ath (Check only on	-/		
this cr	2	1 Yes 2 No		t 2 ER/Outpatie		ther: 4 Nursing				city)
the fire	lon:	27. Manner of Death 1 ☐Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury	W		28d. Describe ho	ow injury	/ occurred	
r death. r death. sctor: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be		ry - At home, farm, st		JYes 2□No	28f Location (St	reet and	1 Number or Pi	ural Route Number.
after death. Director: A	Certification:	4 Homicide determined	building, etc.	(Specify)	ileet, lactory, offic	в	City or Town			ara, riodie rvanber,
- D		29a. Certifier 1 Sertifying Phy	ysician: To the best o	f my knowledge, dea	th occurred at the	time, date and place	e, and due to the c	ause(s)	and manner as	s stated.
our			niner: On the basis of and manner stat	examination and/or in						
24 hours e Funera letely fille	dic	01.0)			29c. Lice	nse number	2	9d. Date	e signed (Mont	h, Day, Year)
within 24 hours To the Funera completely fille	Medical	29b. Signature and title of certifier								
within 24 hours after To the Funeral Directory completely filled in by	Medic		cmo		DI	8019		JUM	VE 6.	2004
within 24 hours To the Funera completely fille	Medic	29b. Signature and title of certifier		ath (Item 23a) (Type	, Print)	8019 HAGER				

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 200 UA Thomas Richard Wayne /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deat Examiner Caroline 18170 Henderson Rd Marydel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March 12, 1 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 ☐ F Director 52 1952 Delaware 221-40-4775 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23s or 28s-f show 1 ☐ Yes 2 X No Director Maryland <u>Caroline</u> <u>Marydel</u> 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number with 21649 U.S.A. 18170 Henderson Road death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Yes 2 ∑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 Disabled Disabled Pages 1 and 2 should be filed v tment of Health and Mental Hygie tent: If Item 27 is marked other t jury or other traumatic svent, III. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Willard Thomas Edith Mary Luff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marydel, MD 21649 18161 Henderson Rd Carol Sparks sister 20b. Place of Disposition (Name of cometery crematory or other place)
Sharon Hills Date 20a. Method of Disposition 20c. Location - City or Town, State 1 🂢 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) crtant: it 06/21/2004 Dover, Delaware Memorial Park permit.
Deportra
Importe
any nju 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Fleegle and Helfenbein Funeral Home PA luge PO Box 160 Greensbore, Mary1and 21639

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final INFARCTION Physician OCARDIAL disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CARDIDVASCULAR PERTENSIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physicien Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ó in the past 12 months? Month Day Year 4☐Pregnant at time of death signed by the at d be detached fo 5 Other (specify) 2 🗆 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed' 1 Yes the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Cthen 4 ☐ Nursing Home 5 MResidence 6 ☐ Other (Specify) ၉ 1 € Yes 2 No 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: or Attending 1 Natural Injury after death. investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funeral L To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29d. Date signed (Month, Day, Year, Singanire 29b empleted cause of death (Item 23a) Christian Er DENTON MD 21629 Jensen 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Sparte N Registrar

			1 ➡ For State Registrar	State of Mary		artment of rtificate of			iene	20372
H	Physic	ian	Decedent's Name (First, Middle, Las	•				2. Date of Death Month	Day Year	3. Time of Death
	/Medi Examir		Gloria Thoma 4a. Facility Name (If not institution, give			4b. City, Town,	or Location of Dea		8 3004 4c. County of Deat	
			Doctors Communi				Lanham			George's
b	Funeral Director		435-42-9922	TM 2XTF	yrs. last birthday) 74 Yrs.	If Under 1 Yea Months Days			Year) Co	hplace (State or Foreign untry) Duisiana
	rland ow		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	cation				10d. Inside City Limits
	e Mary Sa-f sh	ctor	DC		T. T. T. T. T. T. T. T. T. T. T. T. T. T	Vashingt	on			1 X Yes 2 □ No
	h with th	Funeral Director	10e. Street and Number 4400 Dubois E	lace, S.E.		10f. Zip Code	20019	10	og. Citizen of What Co United S	•
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or Items 23a or 28a-f show importent: If item 27 is marked other than "naturel", or Items 23a or 28a-f show any Injury or other treumatic event, The Medical Examinar must be notified at 2008.	þ	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of f Yes, specify Cu 1 ☐ Yes 2 1 No		Specify Yes or No- nto Rican, etc.)	14. Race - Ame Black, White Specify:	
215-0036	within 72 ho ene. than "natur he Medical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)		16a. Deced (Give life.	lent's Usual Occu kind of work done OO NOT use retire	ipation e during most of wo ed)	orking 1	6b. Kind of Business/	Industry
2	filed will Hygien other th		12th 17. Father's Name (First, Middle, Last)		A:	ir & Spa	ce Museur		Governm	nent
anc	ld be fi ental H ked of ic ever	To Be	Walter Thoma	S				me <i>(First, Middle, M</i> Ethal Dand		
Maryland	2 should and Men is marke eumatic		19a. Informant's Name/Relationship (7	ype, Print)			t and Number or F	ural Route Number,	City or Town, State, Z	îp Code)
	1 and Health em 27 ther tr		Winfield Thomas 20a. Method of Disposition		0b. Place of Dispo		is Pl., S	S.E. Wash.	, DC 2001	
mor	Pages nent of i int: If it		1 ☑ Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specify	Removal from State	cemetery, crer Harmony 1	natory or other pla			Landover	
Baltimore,	permit. Departm Importer any Inju		21. Signature of Huneral Service Licen			. Name and Addr	ess of Facility	stewart Fu	neral Home	2
	Pnysician /Medical		23a. Part - Enter the disease, or come shock, or heart failure. List only immediate Sause (Final disease or condition resulting in death)	lications that caused the one cause on each line. a	death. Do not ent	er the mode of dy	ing, such as cardia	c or respiratory arre	st,	Approximate Interval Between Onset and Death
8760,	eate be executed by sicien and the burial-transit	dical Examiner	Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to lor as a co	nsequence of):	5-€	NEN	r p) ISEASE	
O. Box 6	The law requires that the death certificate be executed the sace signed by the attending physicien and oate 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of particles of partic	Fetal death 3	Ectopic pregnand	су		23d. Date of deliv	very Day Year
ords, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions of		t resulting in the u	nderlying cause g	ven in Part I.	23e. Did toba	acco use contribute to	the cause of death?
al Records,		Completed						24a. Was an autopsy perform	prior to c	topsy findings available ompletion of cause of
of Vital	Physicien: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼ No	Hospital: 1 Impatient	2 ☐ ER/Outpatien	t 3□ DQA Ot	h	ath (Check only one		
ion of	ding T. After fune	tion; To	27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	28b. Time of	28c. Inju		28d. Describe hov	nce 6 Other (Spec vinjury occurred	79)
Division		Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, stre	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Rui State)	al Route Number,
	To the Hospitel or within 24 hours after To the Funerel Dirt completely filled in I	edicai (29a. Certifier (Check only one) 1 Certifying Ph	vsician: To the best of my iner: On the basis of exa and manner stated.	y knowledge, death mination and/or inv	occurred at the trestigation, in my	ime, date and plac opinion, death occ	e, and due to the cau urred at the time, dat	use(s) and manner as to and place, and due	stated. to the cause(s)
	withi To t	Σ	29b. Signature and title of certifier				se number	_	d. Date signed (Month,	
•	(2)		20 Nome and address of	omploted course of the ri	(Itam COs) Tr		5818	_	6-08	-2004
R	(3)		30. Name and address of person who ce CECIL GEOLGE	M.S. 7305	- A HANG	STERC PA	RKWAY	GRESNI	BELT MD	20770
	Sta Registi		31. Date filed (Month, Day, Year) JUN 1 1 2004	22. Registrar's S	Signature Apac	w				20770

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Contificate of Death

				For State Registrar	State o	f Maryla		partment of ertificate o			lental Hy	giene Reg. No.	001	4 6	20373
	they a	100		1. Decedent's Name (First, Middle,	Last)						2. Date of De	eath			3. Time of Death
		Physici		Dorothy		Tri	iesdale				Month	Day	20	ear	7:50AM
		/Medic		4a. Facility Name (If not institution,	aive street and nui	_			, or Loc	ation of Death	70,00		County of		
		CXamin	·	Doctors Hospital				Chever	1 17			Pı	rince	Geo	roes
					3. Sex	7. Age (In y	rs. last birthd	ay) If Under 1 Ye	ar If l	Under 24 Hrs.	8. Date of Bi	rth		. Birthpl	ace (State or Foreign
		uneral irector		577-64-5931	1 □ M 2 🖸 F	50	Yrs	Months Day	ys H	ours Min.	(Month, Da			Count	try)
				Usual Residence of Decedent							DCC. Z	J , 1.	/ · ·		
	ylan	MOU THE		10a. State 10b. County		10c.	Cîty, Town or	Location						10	d. Inside City Limits
	ĭa.	le de	tor	Maryland Prince	Georges	I	lyattsv	ville							1 XYes 2 No
	h the	128	irec	10e. Street and Number				10f. Zip Code	е			10g. Citiz	zen of Wh	at Count	try?
	h Wit	33a o	교	5107 70th Ave.				207	84			Unit	ted S	tate	es America
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1	after	or Ite	F	1 ☐ Never Married 2 🔀 Marrie				1 ☐ Yes 2 ☐ N		oecify:	riidari, oto.)			White, e	lack
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(1)	ind Bed	d other	Be	17. Father's Name (First, Middle, L. James Davis	ast)						e (First, Middle Johnso		Sumame)		
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ES	C -	item 27 i		Boyce Clinton Tr	uesdale/			70th A							
3	altimore,			20a. Method of Disposition 1 □ Burial 2 □ Aremation	3 □Removal from	State	cemetery,	sposition (Name of crematory or other p	olace)		Date	20c. Lo	cation - Ci	y or lov	wn, State
16	Pag Pag	ant:		* 4 ☐Donation 5 ☐ Other (Spe	ecify)		Fort Li	ncoln Ce		6/7/2		Brer	itwoo	d, M	laryland
1.	Balti Permit.	Important: If any injury or once.		21. Signature of Finaral Service Li				22. Name and Add Fort Line	dress of	Facility Funera	al Home				
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				23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that only one cause on e	aused the deach line.	leath. Do not	enter the mode of o	tying, su	ich as cardiac	or respiratory a	irrest,			Approximate Interval Between
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	Box eath cert	attending p I for use as	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, ou 1⊟Live b	tcome of pre pirth 2 P		3 Ectopic pregna	псу			2	3d. Date of		y Day Year
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	<b>P</b> . is	i by t etach	by Physician/M	9 Unknown							00 0:4				
	S T Se	gne bed		Part II. Other significant condition				1.0		~			1		cause of death?
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	la w c	as be	Completed	Ane	mia						24a. Was		24b. We	re autop	sy findings available
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	ita is	ortific ctor,	Be (	25. Was case referred to medical examiner?					26.	Place of Deat	h (Check only	one)			
	f V	l dire	2	1 Yes 2 No	Hospital: 1	Apatient 2	2 🗆 ER/Outpa	tient 3 DOA	Other: 4	Nursing Ho	me 5 🗆 Resi	dence 6	Other	(Specify)	
	Division of Vital Records, P.O. or Attending Physician: The law requires that the de	fter th		27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date (Mon	of Injury th, Day Year	28b. Time Injui		ijury at Vork?		28d. Describe	how injury	occurred		
	ondin	or: A	Certification:	2 Accident investiga	ation					2 🗆 No					
	Vis	rector by t	tific	3 Suicide 6 Could no 4 Homicide determin	and 280. Place	of Injury - A	At home, farm, ecify)	street, factory, offic	<b>&gt;</b> e		28f. Location ( City or To	Street and wn, State)	l Number	or Rural	Route Number,
	ital o	within 24 not stater death:  To the Fundarial Director. After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as													
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	,			1 / Vagr	15-201-			DO	02	-101	,	06	-03	- 0	T
0 1	2/	5)		30. Name and address of person we Pragna - 13	ho completed caus	se of death (	Item 23a) (Ty	pe, Print)	V (4-	polisi	rd #	11	131	ade	nsburg
				of Data filed (Atracts 2)	Ture!	y U		00 114		1	mi	. 20	71	2	,
		Sta	ite	31. Date filed (Month, Day, Year)	14	eyistrar's S	ignatu <del>re</del>								

# Taylor, Demetrius La Juan

Ва	perm Dep
THE PERSON NAMED IN	Pnys /Me Exai
Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

			State of Maryland / Depar	tment of Health and	-	•
			. 103.01.01	ificate of Death		Reg. No. 1 2 1 3 7 1
	Physicia	an	1. Decedent's Name (First, Middle, Last)		2. Date of Dea	Day Year
	/Medic	al	Demetrius LaJuan Taylor  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deat	June	3 2009 10: 20 AM  4c. County of Death
	Examin	er	Doctors Community Hospital	Lanham	n	Prince Georges
	Funeral	-	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year   If Under 24 Hrs		
	Director		578-13-3563 1□ M 3₽ F 27 Yrs. Usual Residence of Decedent	Months Days Hours Min.	08 09	76 Washington, DC
	land ow		10a. State 10b. County 10c. City, Town or Local	ition		10d. Inside City Limits
	Mary F-f sh	tor	MD Prince George's Landover	HI11s		1XTYes 2 ☐ No
	death with the Maryland ms 23a or 28a-f show	Director	10e. Street and Number	10f. Zip Code		10g. Citizen of What Country?
	238 (238)	al D	7513 Buchanan Street	20784		USA
	tems	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Amed Forces?  13. Was Decedent Ever in U.S. African Status	as Decedent of Hispanic Origin? (S res, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.
20	s afte	by F	1 □ Never Married 2 【 Married 1 □ Yes 2 【 No If Yes, Give 1 ☐ 3 □ Widowed 4 □ Divorced Year or Dates:	☐ Yes 2☑ No Specify:		Specify: Black
15-0036	tural	edt	15 Decedent's Education 16a Decede	nt's Usual Occupation		16b. Kind of Business/Industry
	nin 72 in "ne Media	plet	(Specify only highest grade completed) (Give kii Elementary/Secondary (0-12) College (1-4or 5+)	nd of work done during most of wo ONOT use retired)	rking	Regis Corporation
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<u>a</u>	s 1 and 2 should f Health and Mer item 27 is marke other traumatic			Address (Street and Number or Ri		
ΰ	of Health item 27		20a Mathod of Disposition 20b. Place of Disposit	Buchanan St. Lan	Date H1	20c. Location - City or Town, State
<u> </u>	ages ant of it: if it		1	tory or other place) c Cemetery 6-9-	04	Washington, D.C.
Baitimor	permit. Pages Department of I Important: If ite any injury or of		Carrier Carrier (epseny)	Name and Address of Facility MA		
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	Pnysician	8 JJ	Immediate Cause (Final disease or condition MALIGNANT	CAMBIAC	- AR	Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):			
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o n	ath ce	ian/		ctopic pregnancy		23d. Date of delivery  Month Day Year
j	the de	Physician/M	1 ☐ Yes 2 ☒ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5 ☐ C	Other (specify)		
ŗ	w requires that the de been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting in the und	erlying cause given in Part I.	23e. Did to	obacco use contribute to the cause of death?
cords	requires that een signed b hould be deta	ed by			1 🗆 Y	es 2 ♠ o 3 Probably 4 Unknown
ဓင္ပဝ		ompleted			24a. Was a	
r	i <b>cian</b> : The lav certificate has rector, page 2	Com			autops perfor 1 ☐ Yes	med? death?
IIa	ysician: is certific director,	Be	25. Was case referred to medical examiner?		ath (Check only or	
5	8 8 =	L 2	1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient			ence 6 Other (Specify)
	B 0 0	lon	27. Manner of Death  1 X Natural 5 □ Pending (Month, Day Year)    Sa. Date of Injury (Month, Day Year)	28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	28d. Describe h	ow injury occurred
UIVISION	Attending r death. ector: After by the fune	fical	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, stree		28f. Location (S	Treet and Number or Rural Route Number,
2	al or / s after ! Dire	Certification:	4 Homicide determined building, etc. (Specify)	, ,	City or Tow	n, State)
	To the Hospital or Attendin, within 24 hours after death. To the Funeral Director: Att completely filled in by the fun		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death of 2 Medical Examiner: On the basis of examination and/or investigation.	occurred at the time, date and place	e, and due to the c	cause(s) and manner as stated.
)	the H hin 24 the F nplete	Medical	one) and manner stated.			
	To To	~	29b. Signature and title of contilion	29c. License number		29d. Date signed (Month, Day, Year)  6-04-2004
•			30. Name and address of person who completed cause of death (Item 23a) (Type, Pr		_ (	JU-04-2007
			Dr. Cecil George, M.D. 8118 Good Luc	•	MD.	
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature			
	Registr	ar	JUN 0 8 2004 Bleen Mr species			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) **Physician** 2056.M TORAIN JASHJUANTI /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer)
May 19, 1976 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min. Wash., D.C. 1 ☐ M 2 🔀 F 28 Director 217-86-6870 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f ehow other traumatic event, the Medical Examiner must be notified at 1 Nes 2 No Washington Director D.C. 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number United States 20018 or Itams 23a 3007 Channing St., S.E. Completed by Funeral illed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕱 No 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specity: Specify: If Yes, Give Year or Dates: 3 Widowed 4 Divorced **Black** "naturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Telemarketer Telemarketing 17. Father's Name (First, Middle, Last) 18 Mother's Name /First Middle Meiden Sumame! Be If Health and Mental I Pages 1 and 2 should be Laraine Herndon Bobbie L. Torain 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2350 Jameson St. Temple Hills, Md. Jean Garrett / Aunt Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages:
Department of IImportant: If Ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State Zion Cemetery 6-10-04 Baltimore, Md. 1 4 □Donation 5 Other (Specify) 21. Signature of uneral Service Licer 22. Name and Address of Facility Capitol Mortuary, Inc. XW1425 Maryland Ave., NE Wash. DC 23a. Parl 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line Immediate Cause (Final death. Do ny Approximate Interval Between Onset and Death inter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition llugrove Pnysician resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter undarlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not regulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 1 ☐ Yes 25. Was case referred to medical examined?

1 Yes 2 No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) = R/Outpatient Certification: To 1 Inpatient 3 DOA 27. Manne of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1. Natural Injury 1 Tes 2 No death. 2 Accident investigation the within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and prig of certifier 29d. Date signed (Month, Dey, Year) cause of death (Item 23a) (Type, Print) MINTERON Colensa 31. Date filed (Month, Day, Year)
JUN 0 8 2004 32. Registrar's Signature State JUN 08 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Rag. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 4:55 Рм 2004 June Margaret R. Thomas /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Annapolis Anne Arundel 2608 Quiet Water Cove If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days 1□M 2₩F Hours Yrs 91 1912 Maryland Director 215-40-7787 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Anne Arundel <u>Annapolis</u> 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number or Itams 23a 2608 Quiet Water Cove 21401 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Itan any injury or other traumatic event, Ita Medical Examination. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be Thomas Everett Grierson Christina Goetz 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Riva, M 3039 Pike Drive Maryland 21140 Carol Bell / Daughter 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Cemetery 6/11/2004 * 4 □ Donation 5 □ Other (Specify) Glen Burnie, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home, Inc 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) D uzuwania **Physician** 2048 Dirapay /Medical Due to (or as a consequence of): Examiner BREEL weiss. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence ot): Examiner ed by the attending physicien and detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy lor in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 \ No 1 Yes 2 No 1 Tyes 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 esidence 6 Other (Specify) Hospital: 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this To the Funeral Director: After the completely filled in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide To the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and little of certifier 30768 who completed cause of death (Item 23a) (Type, Print) 32. Regis Ar's Signature 31. Date filed (Month, Day, Year) State Registrar

			1 - For State Registrar	State of Marylan	d / Depa		lealth and	Mental Hy	giene	20378
			1. Decedent's Name (First, Middle, Last)					2. Date of Dea		3. Time of Death
	Physici -/Medio		Grace I	rene	Curnips	seed		June	8, 2004 Year	6:00 A ^M
	Examir		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, o	r Location of Deat	h	4c. County of Death	
			17018 Birch Leaf	Terrace		Bowie			Prince Geo	orges
	Funeral Director		214-38-8191	M XXF 7. Age (In yrs.	last birthday) 94 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Day		place (State or Foreign
	and *		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	v. Town or Lo	cation			1	10d. Inside City Limits
	Aaryl f sho	ō	M1 C		<b>.</b>					1 TyYes 2 □ No
	the 1 28a-	Funeral Director	Maryland Prince Go	eorges Bow	re	10f. Zip Code			10g. Citizen of What Cour	21
	With With	Ö	17018 Birch Leaf	Terrace		20716	5		U.S.A.	y.
	leath Ins 23	era		2. Was Decedent Ever in U.	S. 13. V			Decify Yes or No-		can Indian
"	r Iten	표	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 No		Vas Decedent of H f Yes, specify Cuba		to Rican, etc.)		etc.
93	urs a	by	3 🕅 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		∏Yes 2Ã No	Specify:		Specify: BI	ack
0	within 72 hours after death with the Maryland ene. then "naturel", or items 23a or 28a-f show its Modical Examition must be notified at	Completed	15. Decedent's Educ		16a. Deced	ent's Usual Occup	ation	4.:	16b. Kind of Business/Inc	dustry
21	i within 72 ho jene. r then "natur ine Mudical	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	kind of work done of NOT use retired	during most or wo	rking		
2	TO 100 100 100	Con	4		Со	ok			Food Servic	e
pu	tal High	Be	17. Father's Name (First, Middle, Last)						Maiden Surname)	1
<u></u>	should be and Mental marked o	မ	George Smith				Elizabe	etn	Un	known
Maryland 21215-0036	nd 2 Ilth al 27 is r treu		19a. Informant's Name/Relationship (Type Edward Joseph Good						r, City or Town, State, Zip ie, Maryland	
ē,	s 1 an if Heal item 2 other		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of natory or other place	1	Date	20c. Location - City or To	wn, State
Baltimore,	Pages nent of I nnt: ff ite		1 ☐ Burial 2 🌠 Cremation 3 ☐ Re  `4 ☐ Donation 5 ☐ Other (Specify)	miloval monti State		matory of ourier place		2/2004 V	Waldorf, Mar	vland
Ħ	그 든 분 분		21. Signature of Funeral Service License	9	22	. Name and Addres	1		Evans Funer	
ä	Depar Depar Impo		De thank	•	16	000 Annap	oolis Roa	ad, Bowie	e, Maryland	20715
,	Physician /Medical Examiner		23a. Pant 1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequ	-AKI	SIAC	ARRE	T, PRI	BABLY	Approximate Interval Between Onset and Death
8760,	icate be executed physician and sthe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a consequ	ience of):		DIIC N	EART	DISEASE	_20 yus
P.O. Box 6	death certiff e attending d for use as	Physician/Med	## FFEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ory Day Year
Records, F	law requires that fhe as been signed by th 2 should be detache	by	Part II. Other significant conditions cont	ributing to death but not resu			en in Part I.	23e. Did to	bacco use contribute to the	e cause of death?
CO	w requir been si should	lete						24a. Was a	24h Wara autor	osy findings available
al Re	The ate his page	Completed						autops perforr	y prior to con	npletion of cause of
Vital	icier certif recto	Be	25. Was case referred to medical examiner?	ospital:		Othe	ar.	th (Check only on		
o	Phys this ral dii	<u>С</u>	1 Yes 27 No	1 Inpatient 2 I	ER/Outpatient 28b. Time of	3LJ DOA	4 U Nursing H		ence 6 Other (Specify	)
U C	ding T. After funer	lon	1XNatural 5 ☐ Pending	(Month, Day Year)	Injury	28c. Injury Work		280. Describe no	ow injury occurred	
isi	Attending Physicien: r death. setor: After this certific by the funeral director.	icat	2 Accident investigation 3 Suicide 6 Could not be	29a Place of laiuny. At he	ma farm stra		Yes 2 □No	OPE Leasting (Co	track and Muselman Roses	10
Division	s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s after s afte	Certification:	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, rarm, stre	ет, тастогу, опісе		City or Town	reet and Number or Rural n, State)	Houle Number,
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medical	29a. Certifier (Check only one)  1 Certifying Physical Cardination (Check only one)	cien: To the best of my know er: On the basis of examinat and manner stated.	vledge, death ion and/or inv	occurred at the timestigation, in my op	e, date and place pinion, death occu	, and due to the carred at the time, d	ause(s) and manner as sta ate and place, and due to	ated. the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	$\cap$		29c. License	number	2	9d. Date signed (Month, L	Jay, Year)
)			SA	HOL		DI	6347		690	4
			30. Name and address of person who con	pleted cause of death (Item	23а) (Туре, Р					
			S AWSEL 1	000 CAI	NEDI	ZAL S	T V	BALTIY	ORE, MD	21201
	Sta Registr	te ar	31. Date filed (Month, Day, Year) JUN 0 9 20	32. A gistrar's Signat	b A	houls,				

			1 - For State Registrar	State of Marylan		artment of laterate of		R	g. No.	20370
	Physici /Medi		1. Decedent's Name (First, Middle, Last) William Kent					2. Date of Deat Month  June 1	Day Ye	4 0 11
	Examir		4a. Facility Name (If not institution, give s 2701 Lorraine A				or Location of Death		4c. County of C	eath
₩	Funeral Director		5. Social Security Number 6. Sex			If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day, 03/16/	Year) 9.	Birthplace (State or Foreign Country) aryland
	e Maryland 3a-f ehow tillied al	Director	10a. State 10b. County MD Carolin		y, Town or Lo		alsburg			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
336	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or items 23a or 28a-1 show event, the Medical Examination untilled at	by Funeral Dire	10e. Street and Number  2701 Lorraine  11. Marital Status  1 Never Married 3 Married  3 Widowed 4 Divorced	A venue  12. Was Decedent Ever in U. Armed Forces?  1  Yes. Give Yes. Give Year or Dates: 49-	l I		21632 Hispanic Origin? (Span, Mexican, Puerto	ַ		
215-00	hin 72 hou 9. In "natura Medical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation	16a. Deced	lent's Usual Occu kind of work done DO NOT use retire	pation during most of work	king	16b. Kind of Busine	
Ind 21	be dala	Be	12  17. Father's Name (First, Middle, Last)  Harry Webs		Line	Truck	18. Mother's Nam	e (First, Middle, M	faiden Sumame)	nd Light Co
Baltimore, Maryland 21215-0036	12 should h and Mer 7 is marke traumatic	To	19a. Informant's Name/Relationship (Typ.  Diane Webster/	oe, Print)			and Number or Rui		City or Town, Stat	
more,	es 1 a of Hea fitem	1 3	20a. Method of Disposition 1 ★ Burial 2 Cremation 3 R. 4 Donation 5 Other (Specify)	20b. P	lace of Dispos emetery, crem	sition (Name of patory or other pla	ice)	Date 2	20c. Location - City	MD 21632 or Town, State , Maryland
Balt	permit. Pag Department Important: I eny injury o		21. Signature of Funeral Service License		22.	Name and Addre	ess of Facility Fra	amptom ]	Funeral	Home, P.A. MD 21632
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on immediate Cause (Final disease or condition resulting in death)	cations that caused the death e cause on each line.  Due to (or as a consequ	Rin.	SONIS	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death  4 2 2 7
8/60,	ecuted and I-transit	dical Examiner	Sequentially list conditions, I any leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ						
O. Box 68	uires that the death certificate be ex signed by the attending physician d be detached for use as the buria	Physiclan/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown	ac. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de	death 3 🗌	Ectopic pregnance Other (specify)	у		23d. Date of Month	delivery Day Year
ecoras, P	law requires that the death as been signed by the atten 2 should be detached for u	by	Part II. Other significant conditions confi	1 0		derlying cause giv	ven in Part I.	23e. Did toba	4	to the cause of death?  Probably 4 □Unknown
	The ate h page	Completed	,					24a. Was an autopsy perform	ed? prior t	autopsy findings available o completion of cause of ? es 2 \( \) No
Vision of Vital	Attending Phy r death. ector: Alter this by the funeral o	ertification; To Be	25. Was case referred to medical examiner?  1	28a. Date of Injury (Month, Day Year)	PVOutpatient 28b. Time of Injury	28c. Injur Wor M 1	ner: 4 □ Nursing Ho y at rk? Yes 2 □ No	28d. Describe how 28f. Location (Stre	oce 6 Other (S) vinjury occurred eet and Number or	Decify) Rural Route Number,
5	To the Hospital or within 24 hours afte To the Funeral Dir. completely filled in I	edical Cert	29a. Certifier 1 Certifying Physi	building, etc. (Specify, icien: To the best of my known er: On the basis of examinating the basis of examinating the basis of examinating the basis of examinating the basis of examinating the basis of examinating the basis of examinating the basis of examinating the basis of examinating the basis of examinating the basis of examinating the basis of examinating the basis of examinating the basis of examinating the basis of examinating the basis of examinating the basis of examinating the basis of examinating the basis of examinating the basis of examinating the basis of examinating the basis of examinating the basis of examinating the basis of examinating the basis of examinating the basis of examinating the basis of examinating the basis of examinating the basis of examinating the basis of examinating the basis of examinating the basis of examinating the basis of examinating the basis of examinating the basis of examinating the basis of examinating the basis of examinating the basis of examinating the basis of examinating the basis of examinating the basis of examinating the basis of examinating the basis of examinating the basis of examinating the basis of examinating the basis of examinating the basis of examinating the basis of examinating the basis of examinating the basis of examinating the basis of examinating the basis of examinating the basis of examinating the basis of examinating the basis of examinating the basis of examinating the basis of examinating the basis of examinating the basis of examinating the examinating the examinating the examinating the basis of examinating the examinating the examinating the examinating the examinating the examinating the examinating the examinating the examinating the examinating the examinating the examinating the examinating the examinating the examinating the examinating the examinating the examinating the examinating the examinating the examinating the examinating the examinating the examinating the examinating the examinating the examinating the examinating the	viedoe death	occurred at the tir	me, date and place,	City or Town,	Isa(s) and manner	as stated.
	To the I-within 24 To the F-complete	Medi	29b. Signature and title of certifier	and manner stated.	on and or my					
			30. Name and address of person who con	npleted cause of death (Item	23a) (Type, P	rint) COVVAL	Sti	Domin	n m	2164 21639
	Sta Registr:	-	31. Date filed (Month, Day, Year)	32. Registrar's Signati	ure Anna		U1. K	WITCH ITC	MIIII)	a lun /

John Thomas Watkins

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

4b. City, Town, or Location of Death

Takoma Park

н	Funeral Director		104-14		1⊠M 2□F	82	Yı	Mo	onths Days	Hours	Min.	(Month,	Day, Yo
200	district to the second	į.	Usuel Residence o			02				1	<u></u>	an.	14,
	tand w		10a. State	10b. County		10c. Cit	y, Town	or Locatio	n				
	s 1 and 2 should be fited within 72 hours after death with the Maryland f Health and Menial Hygiene. It marked other than "naturel", or Items 23a or 28e-f show other treumatic event, the Medical Examinations in colling	tor	Md.	Princ	e George	es	Вс	owie					
	7.28e	Director	10e. Street and Nu	mber				1	Of. Zip Code				10g.
	h with		2304 I	Hillman	Place				20	0716			
	deat	Funeral	11. Marital Status		12. Was Decede	ent Ever in U.	S.	13. Was	Decedent of H	lispanic Orig	gin? (Spec	ify Yes or	No-
9	atter or Ite	/Fu	1 🗆 Never Man	ried 2X Married					Yes 2⊠ No	Specify:	, , , , , , , , , , , , , , , , , , , ,	10411, 0101,	r
8	urel'.	d by	3 🗌 Widowed	4 Divorced	Year or Date	es:			163 200 110	opcony.			
5	natu	ete	(Spe	<ol> <li>Decedent's cify only highest of</li> </ol>	Education grade completed)		16a. C	Give kind	s Usual Occup of work done NOT use retired	ation during most	of workin	g	161
12	2 should be fited within and Mental Hygiene. Is marked other than eumatic event, Ita M.	Completed by	Elementary/Seco	ondary (0-12)	College (1-4	or 5+)			1 Engi				
9	fited Hygie other	Co	17. Father's Name	(First, Middle, La				, <b></b> .	r rugi		r's Name	(First, Mid	idle, Mai
an	ould be fited with Mental Hygiene arked other than atic event, Itel	To Be			Carroll	Watki	ns				Kath	erin	ne F
2	2 should and Mer Is marke eumatic	-	19a. Informant's N	lame/Relationship	(Type, Print)		19b. I	Mailing Ad	dress (Street	and Numbe	r or Rural	Route Nu	mber, C
Ma	and 2 :salth ar n 27 is		Helen	T. Wat	kins-Wif	e	23	304 1	Hillma	an Pl	ace,	Bov	wie,
ē,	s 1 and t Health Item 27 other tr		20a. Method of Dis	,		20b. P			n (Name of ry or other plac	the second second	6-1 ^{Da}	Ologo and the second	200
9	Page ent o ht: If ry or			☐ Cremation 3 5 ☐ Other (Spe	☐Removal from Sta cify)				art Ce			-04	Вс
Baltimore, Maryland 21215-0036	permit. Pages 1 ar Department of Hea Important: If item any injury or other once.		21. Signature of F		**	2 1	11		me and Addre	-		11 F	711 n 4
ä	Depa Impo any i			16	11/00	Zall	/		12 N.V				
Ė,	2000		23a. Part1. Enter	the disease, or co	mplications that cau ly one cause on eac	sed the death	n. Do no	ot enter th	e mode of dyir	ng, such as	cardiac or	respirator	y arrest.
	Physician		Immediate Cause	(Final	Q	20.		1					
	/Medical		resulting in death)		a. ue to (or	s a conseq	uence of	1	Cull				
ġ,	Examiner				ST	ola	D						
		ner	Sequentially list co if any, leading to in cause. Enter Under	mmediate eriving	Due to (or	as a conseq	uence of	·):					
	cutec nd ransi	Examiner	that initiated event	s Injury	с.								
ó,	e exe ien a urial-	EX	resulting in death)	Last	Due to (or	as a consequ	uence of	):					
876	ate b hysic the b	llca			d								
Box 68760,	w requires that the death certilicate be executed been signed by the attending physicien and should be detached for use as the burial-transit	Completed by Physiclan/Medical	IF FEMALE:		222 16								
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o.	the de	ysic	1 ☐ Yes 2 9 ☐ Unknown		4⊟ Pregnan 9□ Unknow	it at time of d	eath	5 🗆 Otn	ner (specify) _				_
cords, P.O.	that the ded by	/ Ph	Part II. Other signi	ficant conditions	s contributing to deat	h but not res	ulting in t	the underl	lying cause giv	en in Part I.		23e. D	oid tobac
ds,	sign d be	d b	4.0	e a Tana	2100	dea	lop	Ten				1	☐ Yes
Š	v requ	ete	100		1	ا ا	~ .					24a. W	Man an
Re		mp	_0000	rang	Helen	(acc)	sea	ماسور				aı	utopsy erformed
<u></u>	sician: The la certiticate ha rector, page 2		25. Was case refe	and to modical								1 □ Ye	
Division of Vital Re	Attending Physician: The la ir death. ector: Atter this certilicate has by the funeral director, page 2	o Be	examiner?	No	Hospital:	ations O	ED/O		Oth	000	of Death		
of	Phy r this eral d	. To	27. Manner of Dea		28a. Date of I	Injury	ER/Outp 28b. Tir		28c. Injur	y at	rsing Hom	e 5⊔ H 8d. Descrii	
O	ding th. Atte	tlor	1 Natural 2 Accident	5 Pending investigat		Day Year)	lnį	ury !	Wor	k? Yes 2.⊟≀	Vo		
/isi	Atter r dea sctor	ifica	3 🗀 Suicide	6 Could not determine	280. Place of	Injury - At ho	me, farn	n, street,	factory, office		28	8f. Locatio	n (Stree
ā	al or s afte of in t	ert	4 🗌 Homicide	,	building	, etc. (Specify	<b>V</b> )					City or	Town, S
	To the Hospital or Attending Physician: The la within 24 hours after death. At o the Funerel Director: Atter this certificate has completely filled in by the funeral director, page 2	Medical Certification:	29a. Certifier (Check only one)	1 Certifying 2 ☐ Medical Ex	Physician: To the best	is of examina	wledge, tion and/	death occ	curred at the tir gation, in my o	ne, date an pinion, dea	d place, an	nd due to t d at the tim	the caus ne, date
	To the within 2 To the complet	Mec	29b. Signature and	d title of certifier	and manne	stated.			29c. Licens	e number			29d.
	F 3 F 8		1	1283	1 11		W.	700	1/2	AC	2		7
	(5)		20 Name and add	Earn	no completed cause	of death /Item	230) (T	VOD Brief	160	17	2	1077	1
	Ogo.	16	Deanna	a White	MD., 76	000 Ca			Avenue	e, Ta	koma	Par	ck,

2. Date of Death Month Day Year 0720 M 10 2001 4c. County of Deeth Montgomery Birthplace (State or Foreign Country) 1922 New York 10d. Inside City Limits 1 ∄Yes 2 No Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. White Specify: b. Kind of Business/Industry Structural Engineering iden Sumame) Earls ity or Town, State, Zip Code) Md. 20716 c. Location - City or Town, State owie, Md. eral Home sowie, Md. 20715 Approximate Interval Between Onset and Death 23d. Date of delivery Month Year Day co use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No No No e 6 Other (Specify) injury occurred t and Number or Rural Route Number, State) e(s) and manner as stated. and place, and due to the cause(s) Date signed (Month, Day, Year) une 10, 2004 7600 Carroll Avenue, Takoma Park, Md. 20912

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) JUN 1 1 2004

1. Decedent's Name (First, Middle, Last)

4a. Fecility Name (If not institution, give street and number)

Washington Adventist Hospital

**Physician** 

/Medical

Examiner

32. Registrar's Signature

/Medi	an	1. Decedent's Name (First, Middle, Last) Mary L.	White-Ky	160			June 3	David	Year	3. Time of Death
	cal	4a. Facility Name (If not institution, give			. City. Town, or	Location of Death	Julie 5		County of Deat	
Examir	ner	3302 Swann Road			Suitlan	d		Pr	ince G	eorges
Funeral	-	Social Security Number 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6. September 6.			Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Birti (Month, Da)	5/3/	40 9. Birt	hplace (Stete or Fore
Director		130-30-4364	M 2⊠F 64 74	Yrs.			May 3	19	30 Was	hington DO
1		Usuel Residence of Decedent  10a. State 10b. County	10c. City, To	own or Location	on					10d. Inside City Lim
perfili. Fages I and 2 stroug be they writen it indus and used they warpans. Department of Health and Mental Hygiens. Department of Health and Mental Hygiens. Important: If them 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner runs the notified at 2008.	ţ	Maryland Prince Ge	orges Suit	1and						1 Yes 2 1
r 28a routi	Director	10e. Street and Number		1	Of. Zip Code			10g. Citiz	en of What Co	ountry?
23a c	aD	3302 Swann Road			20746					es America
teme terror	Funeral	TI. Marital Otatos	12. Was Decedent Ever in U.S. Armed Forces?	13. Was	Decedent of Hi s, specify Cuba	spanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14	<ol> <li>Race - Ame Black, Whit</li> </ol>	e, etc.
l'o'l	by F	1 Never Married 2 ★ Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	10	Yes 2 No	Specify:		5	Specify: B1	ack
atura E E	ted	15. Decedent's Edu	cation 16	Sa. Decedent	s Usual Occupa	ation		16b. Kin	d of Business	Industry
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ygien ver th	Con	12		Food S	ervice		/Fire Addition		ernmen	t
od off	Be	17. Father's Name (First, Middle, Last)  Robert Lee Jones				18. Mother's Name Bertha Ne		Maiden S	ourname)	
d Mer marke	To	19a. Informant's Name/Relationship (Ty	roe Print)	9h Mailing A		and Number or Rura		r. City or	Town, State, 2	Zip Code)
th an		Miles E. Kyles/Hus			,	ad Suitla				
Heal tem 2	1 -	20a. Method of Disposition	20b. Place	of Dispositio			Dete		cation - City or	
ent of	1	1 ☐ Burial 2 ☐ Cremation 3 ☐ F 14 ☐ Donation 5 ☐ Other (Specify)	lemoval from State				9, 200	)4 Br	entwoo	d, Marylar
oorta oorta / inju		21. Signature of Funeral Service Licens		22 Na	ame and Addres	s of Facility	EG. 100			
Depar Impo		1 Men Eh		340	I Blade	nsburg Ro	ad Bren	itwoo	d, Mar	yland 2072
nysician Medical xaminer	Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence).  Due to (or as a consequence).	ce of):	age with					
attending physician and for use as the burial-transit	cal	IE EEMALE:	Due to (or as a consequence	ce or):					UF-CC	
y the	Physician/Medl	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ♣ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel dec 4 Pregnant at time of death 9 Unknown		topic pregnancy her (specify)			2:	3d. Date of de Month	livery Day Year
ig ed	by	Part II. Other significant conditions co	ntributing to death but not resultin	g in the unde	rtying cause give	en in Part I.		obacco us /es 2 🔯		the cause of death?
S C C	Completed						24a. Was autop perfo 1 Yes		death?	utopsy findings availa completion of cause of
ate h	Be (	25. Was case referred to medical examiner?				26. Place of Death	n (Check only o	ne)		
ate h		1 ☐ Yes 2€ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/		3 DOA Oth	4   Nursing no				ocify)
us certificate h director, page	10	27. Manner of Death	28a. Date of Injury (Month, Day Year)	b. Time of Injury		y at k? Yes 2 □ No	28d. Describe h			ural Route Number,
us certificate ha director, page	1-	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	an Bu dities Alberta	f						
us certificate ha director, page	Certification: To	1	28e. Place of Injury - At home building, etc. (Specify)	, farm, street,	factory, office		City or Tov	vii, State)		
us certificate h director, page	edical Certification; T	2 Accident 3 Suicide 4 Homicide investigation 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify) sician: To the best of my knowlediner: On the basis of examination and manner stated.	dge, death oc	courred at the tin	pinion, death occurr	and due to the red at the time,	cause(s) a	and manner as place, and due	s stated. s to the cause(s)
s certificate h director, page	Certification: T	2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check	building, etc. (Specify)  sician: To the best of my knowlediner: On the basis of examination	dge, death oc	curred at the tin	pinion, death occurr a number	and due to the red at the time,	cause(s) a	and manner as	s stated. s to the cause(s)

DHMH 17 Rev 1/2001

ORIGINAL

			1_ For State	State of Maryla	nd / Depa		lealth and	Mental Hyg	iene	20200
			Registrar  1. Decedent's Name (First, Middle, Last)		Ce	runcate or	Dealli	2. Date of Deat	g. No. U U 🖖	60006
	Physici	an	Ludie S. Will	1 0 0 0					2004 Year	3. Time of Death
7	/Medic		4a. Fecility Name (If not institution, give s			4h Cihi Taun	- Location of Doc			5:20 p M
	Examin	er	Southern Maryland			4b. City, Town, o		ith	4c. County of Deat	
			5. Social Security Number 6. Sex		lost hirthday	If Under 1 Year	II If Under 24 Hr	S O Data of Birth	Prince Ge	
	Funeral Director			M 2 X 82	Yrs.	Months Days	Hours Mir		Year) 9. Birt 1921 Nort	hplace (State or Foreign untry) ch Carolina
	and		10a, State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits
	Mary 1 eh	ŏ.	Maryland Prince Ge	orgo Cli	nton					1. Yes 2 No
	the 128a	ec	10e. Street and Number	orge   CII	псоп	10f. Zip Code		10	og. Citizen of What Co	
	with Sa or	Funeral Director	10407 Dee Lane			20735			United Sta	*
	leath	era		2. Was Decedent Ever in U	J.S. 13.		lisnanic Origin? (		14. Race - Ame	
·0	fter o	F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 💆 No		If Yes, specify Cuba	an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	Black, White	
93	urs a	þ	3 N Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:		Specify: Bla	ck
Maryland 21215-0036	within 72 hours after death with the Maryland ene. Then "naturel", or Iteme 23a or 28a-f ehow re Maufaal Evanirer name the motified at	Completed by	15. Decedent's Educ		16a. Dece	dent's Usual Occup	ation	1	6b. Kind of Business/	
75	hin 7 an "in Madi	ple	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retired	during most of wi d)	orking		•
2	d wit	no.	12th	in.	Beau	ıtician			Private	
힏	be filed vital Hygie od other l	Bec	17. Father's Name (First, Middle, Last)	-			18. Mother's Na	ame (First, Middle, M	faiden Surname)	
<u>a</u>	Alents Alents rked	ToE	John F. Stevens				Minerva	Birstal		
ary	2 should be and Mental Is marked eumetic ev	_	19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Mailir	ng Address (Street	and Number or F	Rural Route Number,	City or Town, State, 2	lip Code)
	t and 2 Health a tem 27 Is		Josephine Jackson	/ Daughter	10407	Dee Lan	e Clinto	n, Maryla	nd 20735	
altimore,	permit. Pages I and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mantal Hygiens. Department of Health and Mantal Hygiens. Inforceris I is marked other then "naturel", or fleme 23a or 28a-f show any injury or other treumetic event, the Mantal Evanited Evanited Examples. Once.		20a. Method of Disposition		Place of Dispo	sition (Name of matory or other place			Oc. Location - City or	Town, State
Ë	Pages nent of i ent: if ite ury or o		1 ☐ Burial 2 【XCremation 3 ☐ Ro `4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	-	itan Crem	1	-9-04	11022000	TTd med and a
≣	artm ortel inju		21. Signature of Funeral Service License						Alexandria	virginia
ñ	Depa Impo any ir once.		Muelle Ku	000	A.L.	exander S	ro Piko	Funeral Ho	ome lle, Maryla	and 207//7
			23a. Part 1 Enter the disease, or complice shock or heart failure. List only on	cations that caused the dea	th. Do not ent	er the mode of dyin	g, such as cardia	c or respiratory arre	st.	Approximate
			shock or heart failure. List only on Immediate Cause (Final	e cause on each line.	//		1 +.			Interval Between Onset and Death
e l	Physician /Medical		disease or condition resulting in death)	an	int 1	-1mis	latin	)		enthous
	Examiner			Due to (or as a consec	quence of):	Tensio.				
b.J		-	Esquentially list conditions,	Due to (or as a cons	n ce off:	Jensi o	$\sim$			In KnowN
	ted nsit	Examiner	E squantially list curditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	(						
	xecu al-tra	Xar	that initiated events c. resulting in death) Last	Due to (or as a consec	quence of);					
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/89	physicate to the the the the the the the the the the		d							
×	feath certificat attending phy ifor use as th	Physician/Med	IF FEMALE:	Bc. If yes, outcome of pregn	ancy					
Rox	atten for u	ian	in the past 12 months?	1 Live birth 2 Feta 4 Pregnant at time of c	aldeath 3□	Ectopic pregnancy			23d. Date of delimental Month	very Day Year
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ב.	that the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second	P.	Part II. Other significant conditions con	tributing to death but not res	sulting in the u	nderlying cause give	en in Part I	23e Did toba	acco use contribute to	the cause of death?
ecords,	signed by det	by	Dovering		and an area	noonying oddoo givi	on mr care to			bably 4 Zuknown
Ö	w requir been si should	etec	2			_		, , , , ,	20140 001110	Cably 4 [2007]
ခ	The law requires that the tie has been signed by th page 2 should be detached.	Completed	Demantin				-	24a. Was an autopsy	prior to c	opsy findings available ompletion of cause of
		Ö	Congestive he	ent Failine	_			perform 1 ☐ Yes 2	ed? death?	2□ No
VII	sicien: Th certificate irector, pag	Be	25. Was case referred to medical examiner?					ath (Check only one	)	
6	Physicien: this certificinal director,	၉	1 163 2 2 140	Sspital: 1 Impatient 2	ER/Outpatien	t 3 DOA Othe	er: 4 ☐ Nursing I	Home 5 ☐ Residen	ce 6 Other (Spec	ify)
	ing ing	on:	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at </td <td>28d. Describe how</td> <td>injury occurred</td> <td></td>	28d. Describe how	injury occurred	
DIVISION	Attending ir death. ector: After by the fune	cati	2 Accident investigation	3850		M 1 🗆 '	Yes 2□No			
⋛	F # F C	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, str	eet, factory, office		28f. Location (Stre City or Town,	et and Number or Rui State)	al Route Number,
ָ ב	rtal i				1				·	<u> </u>
	I o the Hospital of within 24 hours af To the Funerel D completely filled is	edical	(Crieck Only 2   Medical Examin	er: On the basis of examina	owledge, death	occurred at the time	ne, date and plac	e, and due to the cau	ise(s) and manner as	stated.
	Vithin 24 To the F complete	led		and manner stated.						
	No No No No No No No No No No No No No N	Σ	29b. Signature and title of certifier			29c. License	number	290	d. Date signed (Month)	Day, Year)
•			How Kille	an		504	54	2	UNR, 5	,04
1	(1)		30. Name and address of person who cor	npleted cause of death (Iter	n 23a) (Type,					
_\	·/			Ave 3-4	1 8	>/Vens	besins	MD 200	102	
	Sta Registra	_	31. Date filed (Month, Day, Year)  JUN 0 9 2004	32. Registrar's Signa	ature	٠.				

_1	For State Registrar	otate of Marytan		tificate of l		Mental Hygie	3. No⊋ [] [] [.	20383
	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
il		West				June 2,	2004	12;30P
						th		ath
		-	last birthday)			8 Date of Birth		rthplace (State or Foreig
	10		Yrs.	Months Days		(Month, Day, )	(1919 DC	Country)
	Usual Residence of Decedent							
	7.0	10c. Cit			11-			10d. Inside City Limit
000	rid.				112			1 GYes 2 □ N
בֿ		20						Country?
era			S. 13. V		spanic Origin? (9			erican Indian
Dy run	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:	- 1	f Yes, specify Cuba	Specify:	to Rican, etc.)	Black, Wh	ite, etc.
tea	15. Decedent's Edu	cation	16a. Deced	ient's Usual Occupa	ition	16	6b. Kind of Busines	s/Industry
- be		College (1-4or 5+)			) most or wo	irking		
5			C	lerk				overnmen
e a								
_		no Printl	10h Mailia	- Add (CaA			•	7. 0
- 3								
-	20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of	race,	Date 20	C. Location - City o	MO 20748 r Town, State
						/04	a a b d a see t	
Ť		×	22	. Name and Addres	s of Facility T	ri-State	F/S/In	on, DC
	James E/	mach	9	12 Third	st.NW	., Wash.	D.C.20	001
	Immediate Cause (Final disease or condition resulting in death)	COPD Exaurb	uence of):					Interval Between Onset and Death  Days
E	Cause (Disease or injury that initiated events							
/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live birth 2 Feta	death 3				23d. Date of de Month	elivery Day Year
-	Part II. Other significant conditions cor	tributing to death but not resi	ulting in the ur	nderlying cause give	n in Part f.	23e. Did toba	cco use contribute t	o the cause of death?
0	Dementia, Hype	rtension,	Hx, C	av, Cad		1 🗆 Yes	2 No 3 P	robably 4 Unknow
Completed							d? prior to death?	utopsy findings availal completion of cause of
e a	avaminar?	lanada l		Transition of the second		-		
0					4 🗆 Nursing r			ecify)
Cation	1 Natural 5 ☐ Pending investigation	(Month, Day Year)	Injury			28d. Describe how	injury occurred	
	4 Homicide determined	building, etc. (Specify	y)			City or Town, S	State)	
edicai	29a. Certifier (Check only one)  Certifying Physical Examination  (Check only one)	sician: To the best of my kno ner: On the basis of examinal and manner stated.	wledge, death tion and/or inv	occurred at the tim restigation, in my op	e, date and place inion, death occi	e, and due to the caus urred at the time, date	se(s) and manner a a and place, and du	s stated. e to the cause(s)
				000 1	aumber.	304		
	29b. Signature and title of certifier			29c. License				th. Day, Year)
	29b. Signature and title of certifier			mD	32784		. Date signed (Mon	th. Day, Year)
2	29b. Signature and title of certifier  30. Name and address of person who co  Daniel Tseng 11			Print)	32784	6/		th. Day, Year)
Be completed by Physician/Medical Examiner		Mildred  4a. Facility Name (If not institution, give s  Malcom Grove Ho  5. Social Security Number 6. Sex  577-60-3283  Usual Residence of Decedent  10a. State 10b. County  Md. PG  10e. Street and Number  2407 Kenton Place  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Eductory only highest grade  (Specify only highest grade  Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)  William O'Neal  19a. Informant's Name/Relationship (Ty, Arthur J. West  20a. Method of Disposition  1 Denation 5 Other (Specify)  21. Signature of Funeral Service Licenses  23d. Part1. Enter the disease, of complication of the complete shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, and shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, and shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, and shock or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, and shock or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, and shock or heart failure. List only on Immediate Cause (Final disease)  Cause (Disease or injury that initiated events resulting in death)  And the condition resulting in death)  And the condition resulting in death (Proposition of the conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions condit	Mildred West  4a. Facility Name (if not institution, give street and number)  Malcom Grove Hospital  5. Social Security Number  577-60-3283  1	Malcom Grove Hospital  5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  8. 4	Malcom Grove Hospital  5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 10c. City, Town or Location 10d. PG 10f. Zip Code 20748 11. Marital Status 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent Fill If Yes, 20 No. 11. Yes 20 No. 11. Yes 20 No. 11. Yes 20 No. 11. Yes 20 No. 11. Yes 20 No. 11. Yes 20 No. 11. Yes 20 No. 11. Yes 20 No. 11. Yes 20 No. 11. Yes 20 No. 11. Yes 20 No. 11. Yes 20 No. 11. Yes 20 No. 11. Yes 20 No. 11. Yes 20 No. 11. Yes 20 No. 11. Yes 20 No. 11. Yes 20 No. 11. Yes 20 No. 11. Yes 20 No. 11. Yes 20 No. 11. Yes 20 No. 11. Yes 20 No. 11. Yes 20 No. 11. Yes 20 No. 11. Yes 20 No. 11. Yes 20 No. 11. Yes 20 No. 11. Yes 20 No. 11. Yes 20 No. 11. Yes 20 No. 11. Yes 20 No. 11. Yes 20 No. 11. Yes 20 No. 11. Yes 20 No. 11. Yes 20 No. 11. Yes 20 No. 11. Yes 20 No. 11. Yes 20 No. 11. Yes 20 No. 11. Yes 20 No. 11. Yes 20 No. 20b. Place of Disposition (Name of Camelles) 20b. Place of Disposition (Name of Camelles) 20b. Place of Disposition (Name of Camelles) 20b. 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Place of Disposition (Name of Camelles)	Malcom Grove Hospital  Social Security Number  A Facility Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Security Number  Social Secur	Mildred  4a. Facility Name (If not institution, give street and number)  Al Com Grove Hospital  5. Social Security Number  5. 77 - 60 - 3283  1 M 2 R  7. Age (in yrs. last birmfoat)  5. Tourity Number  5. Tourity Number  5. Tourity Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Tourity Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  6. Sox Number  7. Age (in yrs. last birmfoat)  100. City, Town or Location  Temple Hills  101. Zip Code  207 48  102. Zip Code  207 48  103. Was Decedent of Hispanic Origin? (Spacify Yes or No. In Yes, specify Cuban, Mexican, Puerro Rican, etc.)  10. Type Section  10. Street and Number  2407 Kenton Place  11. Marial Status  11. Was Decedent Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Secu	Mildred  4s. Facility Name (** Indication, give street and runnbey)  Malcom Grove Hospital  5. Social Security Number  6. Sext  5.77-60-0-3283  Usual Residence of Decedent  10s. Site  10s. County  10s. City, Town or Location of Death  10s. Site  10s. County  10s. City, Town or Location  10s. Site  10s. County  10s. City, Town or Location  10s. Site  10s. County  10s. Site  10s. County  10s. City, Town or Location  10s. Site  10s. County  10s. City, Town or Location  10s. Site  10s. County  10s. City, Town or Location  10s. Site  10s. County  10s. City, Town or Location  10s. Site  10s. County  10s. City, Town or Location  10s. Site  10s. County  10s. City, Town or Location  10s. Site  10s. County  10s. City, Town or Location  10s. Site  10s. City, Town or Location  10s. Site  10s. City, Town or Location  10s. Site  10s. City, Town or Location  10s. Site  10s. City, Town or Location  10s. City, Town or Location  10s. City, Town or Location  10s. City, Town or Location  10s. City, Town or Location  10s. City, Town or Location  10s. City, Town or Location  10s. City Town or Location  10s. City Town or Location  10s. City Town or Location  10s. City Town or Location  10s. 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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) June 1, 2004 **Physician** 4:00 р м Washington Violet /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Bethesda Suburban Hospital If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 □ F 77 229-26-7767 Yrs Director Virginia Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel', or Items 23a or 28a-f ehow any injury or other traumatic event, it a Medical Examiner must be rotified an once. 1 Yes 2 No Director DC Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20018 USA 3212 Banneker Drive Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Maritat Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specity: þ Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Nurse 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Rosier Washington Beatrice Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 616 Powhaten Place NW; Washington DC 20011 Robert Steven Williams-Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 6/10/2004 * 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, MD Fort Lincoln Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fort Lincoln Funeral Home Myalint Wolobert 3401 Bladensburg Road; Brentwood MD 20722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 1 year Metastatic Colon Cancer /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to minimize acuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of) Box 68760, Medical Certification; To Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Munknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2□ No 1 Yes 1 Yes 20 No Vital To the Hospitel or Attending Physicien: Newthin 24 hours after death.
To the Funerel Director; After this certifical 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ★Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Division 1x Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier i 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6/1/2004 D37891 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 121 Congressional Ln #409; Rockville MD 20852 MD A. Rajvansmi

DHMH 17 Rev 1/2001

State

Registrar

31. Date liled (Month, Day, Year)

JUN 0 9 2004

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physician	
/Medical	
Examiner	

For

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic svent, the Mindical Exeminer must be notified at once. Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	1 - State Ce	rtificate of Death	Reg. f	1020NL	20385
	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Yeer	3. Time of Death
an	Leonard Scott Wallis			004	10:00 a M
al er	4e. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deeth	
	7502 Edmonston Road	College Park	P	rince Geo	orge's
	Social Security Number     6. Sex     7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Dete of Birth	9. Birth	place (State or Foreign
	577-34-4157 1 [™] 2□ F 79 Yrs.	Months Days Hours Min.	Month, Day, Yea May 28, 19	925 Ten	nessee
	Usual Residence of Decedent				
	10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits
tor	Maryland Prince George's College	Park			1. Yes 2 No
irec	10e. Street and Number	10f. Zip Code	10g. (	Citizen of What Co	intry?
Completed by Funeral Director	7502 Edmonston Road	20740			
Jer	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Spe	cify Yes or No-	14. Race - Amer	
Ē	Armed Forces?  1 ☐ Never Married 2 ☑ Married   1 ☑ Yes 2 ☐ No	If Yes, specify Cuban, Mexican, Puerto I  1 ☐ Yes 2 A No Specify:	rican, etc.)	Black, White	, etc.
by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: WWII	1 ☐ Yes 2 Ø No Specify:		Specify: Wh	ite
ted		dent's Usual Occupation a kind of work done during most of working	16b.	Kind of Business/I	ndustry
pie	(Specify only highest grade completed) (Give life.	DO NOT use retired)			
то	Tec	chnical Writer	U	.S. Gove	nment
Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maid	en Sumame)	
ToE	Leonard Griffith Wallis	Edith	Gray		
0.0		ing Address (Street and Number or Rura			
	Doris Wallis - Wife 7502	2 Edmonston Road, C	College Pa	rk, Mary	Land 20740
1 8	20a. Method of Disposition 20b. Place of Disposition	osition (Name of Dimatory or other place)	ate 20c.	Location - City or	Town, Stete
	1   Burial 2   ACremation 3   Bemoval from State	tan Crematory 06/08	/2004 A1	exandria.	Virginia
		2. Name and Address of Facility Gas			
		4739 Baltimore Ave.			
	23a. Part1. Enter the disease, or complications that caused the death. Do not en	iter the mode of dying, such as cardiac o	r respiratory arrest,		Approximate
	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	. 1 . 6			Interval Between Onset and Death
	disease or condition a. If cute my o curch	ial interction			sudden
	Due to (or as a consequence of):				
-	Sequentially list conditions, if any, leading to immediate b.				
를	cause. Enter Underlying Cause (Disease or injury				
xar	that initiated events c.  resulting in death) Last Due to (or as a consequence of):				
al E					
Medical Examiner	d				
	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deli	very
ian	in the past 12 months?	☐Ectopic pregnancy ☐ Other (specify)		Month	Day Year
yslc	1 Yes 2 No 9 Unknown				
Completed by Physician	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
b b			1 ☐ Yes	2 XNo 3 □ Pro	bably 4 Unknown
etec			04-146	045 14/	
npi			24a. Was an autopsy performed	prior to c	opsy findings available ompletion of cause of
Ö			1□ Yes 2X		2 No
Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)		
은	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie		ne 5 A Residence		ify)
iio	27. Manner of Death 1 ☑Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) Injury	Work?	28d. Describe how in	lury occurred	
cati	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No			
E	4 Homicide determined 28e. Place of Injury - At home, farm, si building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, St	and Number or Hu ate)	rai Houte Number,
Ce					
Medical Certification:	29a. Certifier (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (C				
Jed	one) and manner stated.	29c. License number	204 1	Date signed (Month	Day Year
~	29b. Signature and title of certifier			fune $7$ , $20$	
	Ven helle	D22780	J	une /, 2	JU4
	30. Name and address of person who completed cause of death (Item 23a) (Type		1. /20	0 1 1	MD 20770
		ay Center Drive, Su	iite 430,	Greenbel	t, MD 207/0
ata	31. Date filed (Month, Day, Year) 32. Registrar's Signature				

State

Registrar

JUN 0 8 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Month Yee **Physician** MAY 2004 WILSON 27, 9:30 A ALVIN /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner PRINCE GEORGES 9612 FRANKLIN AVENUE SEABROOK If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours XXM 2DF Yrs. 27, 1929 WASHINGTON.DC Director 579 36 2961 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show rthan "netural", or itams 23a or 28a-f shov the Medical Examiner must be notified at XX Yes 2 □ No Directo WASHINGTON 10g. Citizen of What Country? 10e. Street and Number 10f Zip Code 5311 FOURTH STREET NORTHWEST 20011 UNITED STATES Funeral death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after XXXYes 2 No 1947— If Yes, Give Year or Dates: 1950 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes XX No Specify: Specify: BLACK þ XXWidowed 4 Divorced 1950 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Ith and Mental Hygiene, 27 is marked other than ' r treumatic event, the Ma Elementary/Secondary (0-12) College (1-4or 5+) 12TH LETTER CARRIER U.S. POSTAL SERVICE 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be 1 nent of Health and Mental I ant: If item 27 is marked of JOHN S. WILSON MAHULDA N. JACKSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 9612 FRANKLIN AVE. SEABROOK, MD 20706 CHARLENE WILSON / DAUGHTER permit. Pages 1 and Department of Healt important: If item 2' eny injury or other 900. 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) XX Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) LINCOLN MEMORIAL CEM. 03-JUN-2004 SUITLAND, MD 21. Signature o Funeral Service License 22. Name and Address of Facility
MARSHALL'S FUNERAL HOME OF MARYLAND, INC. 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 2 MONTHS HEPATOCELLULAR CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physicien and s the burial-transit Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical attending for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 4 Pregnant at time of death 5 Other (specify) ed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ CHRONIC HEPATITIS C 1 ☐ Yes XX No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1□ Yes XX No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 XX ther (Specify) DAUGHTER'S Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes XX No 2 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After the Hospital or Attending XX Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death, 2 Accident Director: 3 🗌 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerel Direct 4 Homicide XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) DC 18561 MAY 28, 2004 ZIL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

DAVID J. PERRY

. Date filed (Month, Day, Year)

JUN 0 8 2004

31

32. Registrar's Signature

110 IRVING ST. NW

WASHIGNTON, DC 20010

		1 - For State Registrar	State of Marylai		artment of I		•	giene Reg. No.)	01 00007
Physic	ian	1. Decedent's Name (First, Middle, Last)					2. Date of De	nath Day	Year S. Time of Death
/Medi	cal	Wi11  4a. Facility Name (If not institution, give		Walker		or Location of Dea		0, 2004 4c. County	9:00 A. M
Exami	ner	Kensington Nursin		ation		Kensing			ontgomery
Funeral Director		5. Social Security Number 6. Sept 12. 12. 12. 12. 12. 12. 12. 12. 12. 12.	7. Age (In yrs	. last birthday) Yrs.	If Under 1 Year Months Days			th 19, Year) 5, 1928	9. Birthplace (State of Exeign Country) Jamaica, Indies
pus *		Usual Residence of Decedent  10a, State 10b, County	10c. C	ity, Town or Lo	ecation				10d. Inside City Limits
Maryli -f eho	to	Maryland Montgom	erv	Ken	sington				1 <b>X</b> Yes 2 ☐ No
th the or 28a e noti	lrec		cComas Avenue		10f. Zip Code	1.1112		10g. Citizen of V	What Country?
ath wi	rai	Kensington Nursin	•			20895			West Indies
in to, intally latter A. I.E. I.S. COOO.  Is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, If a Medical Exercites must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 X Married  3 Widowed 4 Divorced	12. Was Decedent Ever in the Armed Forces? 1 ☐ Yes 2 X No lif Yes, Give Year or Dates:	j	Was Decedent of If Yes, specify Cul 1 ☐ Yes 2X No	Hispanic Origin? (: pan, Mexican, Puel pan, Specify:	Specify Yes or No to Rican, etc.)	Specify	e - American Indian, ck, White, etc. y: <b>Black</b>
72 hou	eted	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Dece	dent's Usual Occu kind of work done	pation during most of we	orking	16b. Kind of Bu	usiness/Industry
should be filled within 7 and Mental Hygiene. s marked other than "I umatic event, It a Men	Completed	Elementary/Secondary (0-12) 12th grade	College (1-4or 5+)	life.	DO NOT use retire itation	ed)		BFI-Was	ste Management
filed v Hygie other f	Be Co	17. Father's Name (First, Middle, Last)					me (First, Middle		
uld be Wental	To B	William Samuel	Walker, Sr.			Mirha	am Dei	nnis	
2 sho	ľ	19a. Informant's Name/Relationship (Ty				t and Number or R			
s 1 and 2 of Health of Item 27 is		John Peter Walker 20a. Method of Disposition	20b.	Place of Dispo	sition (Name of	se Drive	Date		d 20720 City or Town, State
Pages nent of I		1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	temoval from State		natory or other pla ashing to	n Cemetei	5,2004		, Maryland
permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Licens	7			ess of Facility Tton Comp			
1 83558		23a. Part 1. Enter the disease, or compl	cury	1	600 Kenn	edy Stree	et,N.W.;	Washingt	con, D.C. 20011  Approximate
Physician /Medical Examiner	her	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	quence of):	sn iz				Interval Between Onset and Death
cate be executed physician and the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quence of):					
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of pregr 1 □ Live birth 2 □ Fel 4 □ Pregnant at time of 9 □ Unknown	al death 3	Ectopic pregnand Other (specify)	су		23d. Dai Mo	te of delivery nth Day Year
law requires that as been signed be detailed.	by	Part II. Other significent conditions con		-	nderlying cause g	iven in Part I.	23e. Did t	_^	nbute to the cause of death?  3 Probably 4 Unknown
din Ol Vital neco ding Physician: The law re h. After this certificate has bee funeral director, page 2 sho	Completed						24a. Was auto perio 1 Yes	psy prmed?	Were autopsy findings available prior to completion of cause of death?    Yes 2   No
vital ician: T sertificat ector, p	Be	25. Was case referred to medical examiner?	Hospital:				ath (Check only o	one)	
Physic rthis ral dir	. To	1 ☐ Yes 2 No  27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatier	II 3 DOA		Home 5 Resident	dence 6 Oth	
tending leath. tor: Afte the fune	ation	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	We	ork? ]Yes 2 ☐ No		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
tal or Attend s after death al Director: ed in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	home, farm, str	eet, factory, office		28f. Location ( City or To	Street and Numb wn, State)	er or Rural Route Number,
To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical	29a. Certifier 1  Certifying Phy (Check only one) 2  Medical Exemi	sician: To the best of my kr ner: On the basis of examin and manner stated.	nowledge, deat ation and/or in	h occurred at the t vestigation, in my	ime, date and plac opinion, death occ	e, and due to the urred at the time,	cause(s) and ma date and place,	nner as stated. and due to the cause(s)
To the To the Comp	M	29b. Signature and title of certifier	20,	70		se number			(Month, Day, Year)
		30. Name and address of person who co	ompleted cause of death (Ite	em 23a) (Type,		Shorefie			
		31. Date filed (Month, Day, Year)	32. Registrar's Sign	Nature	Whea	ton, Mary	land 20	0902	
St	ate	JUN 0 8 2004	32. Hegistrar's Sign	nach!					

			1- For State of Maryland / Department of Health and Maryland / Certificate of Death	Reg	ene
	Physici	an	Decedent's Name (First, Middle, Last)  JOHNATHAN MONTINOUS WASHINGTON	2. Date of Death Month June	Day Year 02 2004 4:26 A M
	/Medic Examin	_	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of Death
			5408 Livingston Terrace Oxon Hill		Prince George's
r	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y 02/10/15	9. Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	02/10/1.	988 Washington, DC
	arylan show	7	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits 1    ↑
	the M	ecto	MD Prince Georges Oxon Hill  10e. Street and Number 10f. Zip Code	100	g. Citizen of What Country?
	3a or	I DI	5634 Livingston Terrance #101 20745	109	U.S.A.
36	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artiment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural, or itams 23e or 28e-f show injury or other traumatic event, the Medical Eracili at final be footlind at 9.	by Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 1 Yes 2 No If Yes, Sive 1 Year or Dates:  13. Was Decedent of Hispanic Origin? (Sp. 16 Yes, specify Cuban, Mexican, Puerton 19 Yes, Sive 1 Yes, Sive 1 Yes 2 No Specify:	pecify Yes or No- p Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: Black
9	2 hou	ted	15. Decedent's Education 16a, Decedent's Usual Occupation	16	b. Kind of Business/Industry
21215-0036	nithin 7	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  Student	Willy	NT / 7
d 2	filed v Hygie other t	о Со	Seading	e (First, Middle, Ma	N/A
lan	fental rked o	To Be		7	shington
, Maryland	permit. Pages 1 and 2 shot Department of Health and N important: If item 27 is ma any injury or other trauma once.		19a. Informant's Name/Relationship (Type. Print) Veronica Washington-Mother  19b. Mailing Address (Street and Number or Rut) 5634 Livingston Te	errance	City or Town, State, Zip Code) MD #101; Oxon Hill
Baltimore,	ges 1 t of He if iten or oth		1 Burial 2 To Cremation 3 Removal from State		c. Location - City or Town, State
Ħ.	permit. Page Department Important: If any injury or once.		14 Donation S Other (Specify) Riverdale Crem. 6/9 21. Signal of Fundal Service Consee R. Algebra and Add @ss of Fibritie em		iverdale, MD
Ba	Depariment in police.		1353 H Street,		ashington, DC
			23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock a heart failure. List only one cause on each line.		t, Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition west west		Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):		
		Jer	Sequentially list conditions, if any, leading to immediate saus. Enter U.J. rly u.g. Cause (Disease or injury		
	cate be executed oblysician and the burial-transit	Examiner	that initiated events C.		
8760,	be exe clan a ourial-	al Ex	resulting in death) Last Due to (or as a consequence of):		
687	certificate be executed Iding physician and Ise as the burial-transit	edical	d.		
O. Box	death e atter	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
٥,	requires that the een signed by th nould be detache	y Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?
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Il Records,	The law ate has b page 2 sl	Comple		24a. Was an autopsy performe 1XYes 2	
Vital	Physician: this certific ral director,	Be	examiner?	th (Check only one)	56
of	D = 0	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	ome 5 Residence 28d. Describe how	be 6 10 Other (Specify) at scene injury occurred
Division	Attending r death. sctor: After y the fune	Certification:	2 Accident investigation 6/2/04 4:10 M 1 Yes 2X No	Subject	+ slift
Ν	i or Attenc after death Director:	rtific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town, S	
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	To the within 2 To the complet	Mec	29b. Signature and title of certifier 29c. License number	29d	. Date signed (Month, Day, Year)
	->		La himuel Al. O.C.M.E.	Jı	une 02, 2004
T	)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  238. Name and address of person who completed cause of death (Item 23a) (Type, Print)  111 Penn Street, Ba	altimore	Maryland 21201
Y	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature		1
DI	Registr		JUN 0 8 2004 Blown It Sparle		

			101	partment of Health and Mental Fertificate of Death	Hygiene Reg. No. 004 20389
24	Physici /Medic Examir	al	1. Decedent's Name (First, Middle, Last)  Wiildred Diane Williams  4a. Facility Name (If not institution, give street and number)  Holy Cross Hospital	2. Date of Month June  4b. City, Town, or Location of Death  Silver Spring	Death Day Year 1. 2004 3. Time of Death 15:10 M  4c. County of Death Montgomery
	Funeral Director		5. Social Security Number 577-96-3162  Usual Residence of Decedent  10a. State 10b. County  6. Sex 1 M 2 M F 7. Age (In yrs. last birthday 3 2 Yrs.	7/30	Birth Day, Year) 9. Birthplace (State or Foreign Country) V 1 r g 1 n 1 Clarks v i lle
	72 hours after death with the Maryland natural', or items 23a or 28a-f show dical Evand wr must be invilibed at	ral Director	Md. Prince Georges Adelphi  10e. Street and Number  8537 Riggs Rd.	10f. Zip Code 20783	10d. Inside City Limits 1 □ Yes 2 X No  10g. Citizen of What Country?  U.S.A.
-0036	hours after des itural, or items	ed by Funeral	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 ☐ Yes 2 ☑ No Specify:  edent's Usual Occupation	No-  14. Race - American Indian, Black, White, etc.  Specify: Black  16b. Kind of Business/Industry
id 21215-0036	lled within lygiene. har than " nt, the Me	e Completed	(Specify only highest grade completed) (Giv.  Elementary/Secondary (0·12) College (1-4or 5+)	e kind of work done during most of working DO NOT use retired)  es Associate  18. Mother's Name (First, Mid	JC Penney- Retail
Maryland	ages 1 and 2 should be find of Health and Mental Ht. If item 27 is marked of y or other traumatic ever	To B	Cornell Davis Terry  19a. Informant's Name/Relationship (Type, Print)  Senoria Williams/ sister 327	Leola Blan  Blan  Burns St., S.E. Wash	mber, City or Town, State, Zip Code)
Baltimore,	permit. Pages 1 an Department of Heal Important: If itam 3 any injury or other once.		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  20b. Place of Disposition cemetery, cre  20b. Place of Disposition National  20b. Place of Disposition networks are selected as a selected selected as a selected selected as a selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected selected sel	position (Name of parameter)  1 Harmony 6/12/04 22. Name and Address of Facility Univer	20c. Location - City or Town, State
	Pnysician /Medical		23a, Part1. Enter the disease, or complications that caused the death. Do not enshook, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.   Embolic Stro	nter the mode of dying, such as cardiac or respirator	
8760,	death certificate be executed  a ettending physician and id for use as the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Sepsis  Due to (or as a consequence of):  Hypotension  Due to (or as a consequence of):  Hypotension  Hypertensive	Cardiomyopathy	
O. Box 6	that the death certifics ed by the attending pr detached for use as t	Physician/Medical		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
<u>α</u>	w requires that the been signed by th should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the Chronic Renal Failure	1[	d tobacco use contribute to the cause of death?  ☐ Yes 2 🖔 No 3 ☐ Probably 4 ☐ Unknown
tal Rec	The law ate has b page 2 sl	e Completed	Insulin Dependent Diabetes M  25. Was case referred to medical	au	topsy prior to completion of cause of death?  s 2 ☑ No 1 ☐ Yes 2 ☐ No
Division of Vital Records,	ding Phys h. After this funeral dii	ation; To B	examiner?  1  Yes 2 X No  Hospital: 1 XInpatient 2 ER/Outpatie  27. Manner of Death 1 X Natural 5 Pending 2  Accident Accident Sinvestigation  Hospital: 1 XInpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Out	ont 3 DOA Other: 4 Nursing Home 5 Re	scidence 6 ⊡Other (Specify) se how injury occurred
Divis	spital or ours afte taral Dir filled in	ai Certification;	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, st building, etc. (Specify)  29a. Certifier  1 ☐ Certifying Physicien: To the best of my knowledge, deal	City or 1	1 (Street and Number or Rural Route Number, Fown, State)  ne cause(s) and manner as stated.
•	To the Hos within 24 h To the Fur completely	Medical	one)  2   Medical Examiner: On the basis of examination and/or in and manner stated.  29b. Signature and title of certifier	29c. License number 47867	e, date and place, and due to the cause(s)  29d. Date signed (Month, Day, Year)  6 / 2 / 0 4
:	Sta Registr		30. Name and Address of person who completed cause of death (Item 23a) (Type, One y/ Zuniga, MD 4701 Randolph 31. Date filed (Month, Day, Year)  JUN 07 2004	Rd., Rockville, Md.	20852

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician Hattve F. Young 05 7:32 04 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist HOspital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 F 94 Director 415-09-1295 01 16 Memphis, TN Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic avent, the Modical Examinar must be notified at 10d. Inside City Limits 1€ Yes 2 No Director Washington D.C. 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 20011 USA 5421 Blair Road N.E. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. 11. Marital Status Black, White, etc. il Hygiene. other then "natural", or Ite 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black à 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 yrs. Social Worker Montgomery County permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked oth any injury or other traumatic avent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Ford Lurenda Lyles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norma Griffin/Niece 1523 South PArk Way East Memphis, TN 38106
Date Date 20c. Location - City of Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Rock Creek Cemetery 6-4-04 Washington, D.C. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MArshall's Funeral Home 23a. Part l'Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. 4217 9th. St. N.W. Washington, D.C. 20011 Approximate Interval Between Onset and Death Gastiniatisthal Immediate Cause (Final disease or condition resulting in death) hemorthese **Physician** /Medical Examiner Parlal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed physician and s the burial-transit Cerchery Gritable Box 68760 Physician/Medical as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav 4□Pregnant at time of death 5 Other (specify) P.O. the 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 ☐ No 1 Tes 202 No 25. Was case referred to medical 26. Place of Death (Check only one. examiner? 1∠Xes 2 No Hospital: 1 Inpatient 2 X ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: To the Hospitel or Attending within 24 hours after death.
To the Funeral Director: After Injury Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CArroll AUE TAKOMA ht Foot 76 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State JUN 0 8 LUU4 Registrar

		•	1 - For State Registrer	State of Mary		artment of F rtificate of I			giene Reg. Noo. O	01	
	ysicia		1. Decedent's Name (First, Middle, Last) Esther L. Arch	ıer				2. Date of Dec Month June 1	Day 2004	Year	Time of Death
	ledic amin		4a. Facility Name (If not institution, give s Wesley Home	treet and number)		4b. City, Town, or Baltimo			4c. County		12.50 IAI
Fun Dire			210-10-0307	M 2⊠F 7. Age (In	yrs, last birthday) 2 Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		h y, Year) 1901	9. Birthplace Country) Maryl	e (State or Foreign and
Maryland -f ehow	led at	tor	Usual Residence of Decedent  10a. State 10b. County  MD	100	. City, Town or Lo	cation timore					Inside City Limits 1    Yes 2 □ No
with the a or 28a	De noti	Director	10e. Street and Number			10f. Zip Code	1000		10g. Citizen of V	Vhat Country?	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	Xaminer mus	by Funeral	2211 W. Rogers At  11. Marital Status  1 Never Married 2 Married  3 Wwidowed 4 Divorced	Venue  12. Was Decedent Ever Armed Forces?  1			1209 ispanic Origin? n, Mexican, Pue Specify:	(Specify Yes or No- ento Rican, etc.)	USA 14. Race Blac  Specify	e - American I k, White, etc.	·
Mail y latter 2 12 10 0000 of 2 2 should be filed within 72 hours aft lith and Mental Hygiene.	ne Medical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12	cation	(Give	dent's Usual Occup kind of work done of DO NOT use retired salesper	during most of w	rorking	16b. Kind of Bu		
ld be filed ental Hygi ked other	ic event, I	To Be Co	17. Father's Name (First, Middle, Last)  Joshua Lynch			Sazospez	18. Mother's N	ame <i>(First, Middle,</i>	Maiden Sumam		Store
nd 2 shou alth and M 27 Is mar	r traumat	_	19a. Informant's Name/Relationship (Ty) Barbara Davidson				and Number or I	Rural Route Numbe	r, City or Town,		de)
Dermit. Pages 1 are Department of Heal Importent: If item.	ry or othe		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ R  4 ☑ Donation 5 □ Other (Specify)	1	b. Place of Dispo cemetery, cren	sition (Name of natory or other plac	θ)	Date	20c. Location -	City or Town,	State
permit. Departn Importe	eny inju		21. Signature of Funeral Service, icense	1 the	Ва	iltimore,	MD 212			ore Str	reet
/Med Exami	ical ner	Examiner	23a. Part 1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.  The conditions of the conditions of the cause. Enter Underlying Cause (Disease or injury that infliated events	Due to (or as a cor	osequence of):			ac or respiratory ar		Inte	proximate anval Batween set and Death
The law requires that the death certificate be executed ate has been signed by the attending physician and	the bu	Physician/Medical Exa	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \[ \sqrt{es} 2 \] No 9 \[ \] Unknown	Due to (or as a cor	egnancy Fetal death 3	]Ectopic pregnancy ] Other (specify)			23d. Date Mor	e of delivery th Day	Year
quires that	Pe Pe	Ď	Part II. Other significant conditions con		resulting in the u	nderlying cause give	en in Part I.		bacco use contri es 2 No		ause of death?
icien: The law requ	, page 2 should	Completed			· · · · · · · · · · · · · · · · · · ·				sy p med2 d	Vere autopsy rior to comple eath?	findings available tion of cause of No
orttending Physicien: The law requires that the death cer after death.  Director: After this certificate has been signed by the attendin	<del>-</del> <del>-</del> <del>-</del> <del>-</del> <del>-</del> <del>-</del> <del>-</del> <del>-</del> <del>-</del> <del>-</del>	ation: To Be	25. Was case referred to medical examiner?  1 Yes 2 No H  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Yea	2 ER/Outpatien 28b. Time of	28c. Injury Work	at Vursing	Home 5 Resid			
oital or Attendurs after deatl	illed in by th	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (Sp	pecify)			City or Tow			
To the Hospital or within 24 hours after To the Funerel Dire	mpletely fi	Medical	29a. Certifier (Check only one)  1  Certifying Phys 2 Medicel Examir one)	icien: To the best of my ner: On the basis of exar and manner stated.	knowledge, death	occurred at the tim vestigation, in my op	oinion, death oc	curred at the time, o	ause(s) and mar date and place, a 29d. Date signed	nd due to the	cause(s)
Ž × Ž	8		30. Name and addlass of person who co	moleted cause of docth	(Item 23a) /Tues			LTI'HORE	_		
	Stat	te	2. VERBARA-SOA	32. Registrar's S	ignature	SERS AVE	· BA	LT HORE	MD.	2120	9

AMEND	TTEM 21 PER FH, G83 名列 26 外域以内的 / Department of Health and Mental Hygiene  Certificate of Death Reg. No. 1 11.	0302
	1. Decedent's Name (First, Middle, Last)  2. Date of Death  Month  Day  Year	3. Time of Death
Physician /Medical	Wilma J. Adams Jone 1 2004	10:25 AM
Examiner	4a Facility Neme (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death	
	Mariner Health of Catensville Catensville Baltimore  5 Social Social Social Number 6 Sex 7 Age (In vis lest hirthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9 Birthologic	- /04-1
Funeral Director	413-50-1685 1 M 2 F 71 Yrs. Months Days Hours Min. 12/726/32 VIRGIN	e (State or Foreign NIA
pu .	Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or Location         10d.	Inside City Limits
Maryla Fed at	ion state	1X Yes 2□No
ifier deeth with the Marylar returns 23e or 28e-f show riner must be notified at Funeral Director	10e. Street and Number  5011 MIDWOOD AVE  10f. Zip Code  21212  USA	?
urs after dec at, or tems Example: III	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	
ed within 72 hours ygiene. ver than "natural", rt, the Wod cal Ex Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  HUMAN RESOURCES  16b. Kind of Business/Indust life. DO NOT user retired)  SOCIAL SECT	
be flied within 72 h tel Hygiene. d other than "natu event, the Wedcal event, the Be Completed	17. Father's Name (First, Middle, Last)	
2 should be on Mentel is marked or raumatic eve		ode)
permit. Peges 1 and 2 should Deportment of Health and Mer Important: If them 27 is marked any injury or other traumatic once.	20a. Method of Disposition  1 Note in the image of Disposition (Name of Cemetery, crematory or other place)  4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of Cemetery, crematory or other place)  DRUID RIDGE CEMETERY  6/7/04 PIKESVILLE, MI	
permit. Depertm Importare any injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and injure and inj	21. Signature of Funeral Servica Licansee  VAUGHN C. GREENE PER DVR  22. VAUGHN C. GREENE FUNERAL HOME 4905 YORK ROAD, BALTO., MD 21212	
	shock or head failure. List only one cause on each line.	pproximate terval Between
Physician /Medical		O days
executed in end inel-trensit	Due to (or as e consequence of):  Multiple Cerebrovascular Accidents	Odays 2 gaus
cate be executed obligation and the buriel-trensit dical Examir	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury c. Chronic Obstructive Almerary Disease Security Secure	
sate be shysicia the bur dical	that initiated events resulting in death) Last  Due to (or as a consequence of):	years
eath certific attending put for use esticle.		
the dear y the a sched f	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23b. Did tobacco use contribute to the	ne cause of death? Dry 4⊠ Unknown
requires that the death certific een signed by the attending p hould be detached for use es sted by Physician/Me	Multiple Sclerosis	
00	24a. Was an autopsy performed? 24b. Were availa composition of dear	autopsy findings able prior to detion of cause ath?
The lew ate has page 2	1 □ Yes 21€ No 1 □ Y	es 2X No
certificate irector, pag	25. Was case referred to medical 26. Place of Death (Check only one)	
Z G Z	1 ☐ Yes 2 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
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tal or Attending Ples of the death.  al Director: After the death by the funere death by the funere Certification:	3 Suicide 6 Could not be determined 4 Homicide 4 Homicide 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural R City or Town, State)	Route Number,
To the Hospital or Attending within 24 hours effor deeth.  To the Funeral Director: Atter completely filled in by the fune Medical Certification	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stete (Check only one)	ed. ne cause(s)
Nithin To the compl	29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Dep	y, Year)
	Bonnie Cohon MD 191797 6/21/04	
10	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
State		
Registrar	JUN 2 9 2004 Server & sparks	

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar AMEND ITEM #3 PER PHY G832 Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Physician Year R obert /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopki BALTI DAYVIEW mort ns If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 220-20-010 Yrs. Director MARYL Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or items 23e or 28e-f show any injury or other treumetic event. If ite Modical Examiner must be notified an once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTIMORE 1 Yes 2 No Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 560 Jummer 21206 Completed by Funeral held Ave 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary.(0-12) College (1-4or 5+) MAKER 10 Elcar rintino 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kohert Abel ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5005 Abell-AVT. Summerfield DALTIMORE Date ) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) of Faith Comotery lo 22. Name and Address of Fallity BALTIMORE MO 21234. 21. Signature of Funeral Service Licensee EVANS FUNERAL CHAPEL 8800 HARFURDRD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cadse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYOCARDIAR Pnysician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequience of): the burial-transit the Hospitel or Attending Physicien: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 2 No 1 Tyes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performen res 2001 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: 1 Inpatient 2 FR/Outpatient 3 □ DOA Other: ပို 1 🗌 Yes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) filled in by the funeral 27. Manner of Deal 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred After Natural 2 Accident Injury death. investigation 1 Yes 2 No within 24 hours after deatl To the Funerel Director: 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medicai Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 04 60 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Val 65 Paul 65 S+, BALTIMORE

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

JUN 2 9 2004

Char

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	State Registra/NEND ITEM	State of Ma 5816A PER	ryland / Deg Fn G832Ce	partment of He 179704 Ja ertificate of C	ealth and Me Death	ntal Hygier Reg. t		20391												
	Physici	ın	1. Decedent's Name (First, Middle, La						Day Year	3. Time of Death												
}	/Medic Examin		4a. Facility Name (If not institution, giv SHADY GROVE		-41	4b. City, Town, or	Location of Death	-	c. County of Deat													
	Funeral Director		5. Social Security Number 6. S		(In yrs. last birthday	•		Date of Birth (Month, Day, Yea	9. Birt	hplace (State or Foreign untry)												
	Maryland -f show	_	Usual Residence of Decedent  10a. State 10b. County  MD N/	i i	10c. City, Town or I	Location				10d. Inside City Limits 1												
	death with the Mi ms 23a or 28a-f Imust be notified	Directo	10e. Street and Number	n Road	5401	10f. Zip Code	212	10g. (	Citizen of What Co	untry?												
36	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene it feath and Mental Hygiene item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Endemed Forces?  1 Types 2 Not Iffes, Give Year or Dates:		. Was Decedent of His		fy Yes or No- can, etc.)	14. Race - Ame Black, White	ncan Indian,												
1215-0036	within 72 hou ene. than "natura ne Medical E	Completed	15. Decedent's E (Specify only highest gr. Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+	(Giv	redent's Usual Occupa re kind of work done di . DO NOT use retired)	uring most of working	VA AV	Kind of Business													
land 21	ould be filed within Mental Hygiene. arked other than " atic event, the Me	To Be Co	17. Father's Name (First, Middle, Last HENRY N. BA		,		18. Mother's Name (		en Sumame) PBCLL													
Maryland	1 and 2 should be Health and Mental em 27 is marked o ther traumatic ev		19a. Informant's Name/Relationship (	Type, Print) SSDMCS		iling Address (Street a.				Zip Code) Wh. MD 20874												
Baltimore,	Page nent o ant: If ury or		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci			position (Name of rematory or other place SON FOR ES		. 1	Location - City or NINGS M	Town, State												
Balti	permit. Par Depurtmen Impurtant: any injury		21. Signature of Funeral Service Lic			22. Name and Address VAUGHN C 5151 PAL	S OF Facility  RECENTED  TIMORE NO	FUNERA ATIONAL F	L SERVIC	CES TO MD 21229												
1	Prrysician /Medical Examiner	ompieted by Physician/Medical Exa	23a. Part1. Erfor the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line	9.	ARY AN			ASE	Approximate Interval Between Onset and Death  VEALS												
68760,	ppital or Attending Physician: The law requires that the death certificate be executed ours after death.  lears Director: After this certificate has been signed by the attending physician and lined in by the funeral director, page 2 should be detached for use as the burial-transit		Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):				· ·												
P.O. Box 68			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at the 9 Unknown	Fetal death 3	B⊟Ectopic pregnancy □ Other (specify)			23d. Date of del Month	ivery Day Year												
			ompieted by	ompieted by	ompieted by	by	by	by	by	by	by	by	by	by	Part II. Other significant conditions	contributing to death but	t not resulting in the	underlying cause give	n in Part I.		_	the cause of death?
of Vital Records,												24a. Was an autopsy performed 1 Yes 2	prior to death?	topsy findings available completion of cause of								
		To Be	25. Was case referred to medical examiner?  1  Yes 2 No							cify)												
Division		Certification;	ertificat	ertifical	2 Accident Investigation 3 Suicide 6 Could not I 4 Homicide determined	De Place of Injur	ry - At home, farm, : (Specify)	street, factory, office	28	f. Location (Street City or Town, Sta	and Number or Ru ate)	ıral Route Number,										
1	Hospita A hours Funera	ledical C	29a. Certifier (Check only one)  1 Certifying P 2 Medical Exa	hysician: To the best of miner: On the basis of and manner stat	examination and/or	ath occurred at the tim investigation, in my op	e, date and place, an inion, death occurred	d due to the cause I at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)												
	To the within To the comple	Me	29b. Signature and title of certifier	ronBe	o uno	29c. License	number 0 5 7 / 2		Date signed (Monti													
4	5	j	30. Name and address of person who DR. TRU ONG																			
	Sta Regist		31. Date filed (Month, Day, Year)  JUN 2 9 20	32. Hegistrai	r's Signature	Spark	-															

BAKER, AUDREY

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9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  1   Yes 2   SNO 3   Probably 4   Unknown  24a. Was an appropriate of the cause of death?  1   Yes 2   SNO 3   Probably 4   Unknown  24a. Was an appropriate of the cause of death?  25. Was case referred to medical systems of the cause of death of the cause of death?  25. Was case referred to medical systems of the cause of death?  26. Place of Death   Check on   one   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   Other   O	687	g phys g phys as the	ledica	d								
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24a. Was an autopsy performed prior to completion of cause of dath?  25. Was case referred to medical examiner?  1		es be	by	Part II. Other significant conditions contri	buting to death but not resulting	ng in the un	derlying cause g	ven in Part I.	23		/	
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29a. Certifier (Check only one)  29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State  29a. Certifier (Check only one)  29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State  31. Date filled (Month, Day, Year)  32. Registrar's Signature	sior	tendin eath. tor: Aft the fun	catio	2 Accident investigation	(Month, Day 19ar)	injury			0			
State  Slanley O Schword D17368  06-24-2004  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  STANLEY A. SCHWARTZ 2101 MEDICAL PARK DR. #2, SILVER SPRING, NO  State  31. Date filled (Month, Day, Year)  32. Registrar's Signature	Divi	al or At after d Direct d in by	ertifi	determined	<ol> <li>Place of Injury - At home building, etc. (Specify)</li> </ol>	e, farm, stre	et, factory, office		28f. Loc City	ation (Street a. or Town, Stat	nd Number or R e)	lural Route Number,
State  Slanley O Schword D17368  06-24-2004  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  STANLEY A. SCHWARTZ 2101 MEDICAL PARK DR. #2, SILVER SPRING, NO  State  31. Date filled (Month, Day, Year)  32. Registrar's Signature		e Hospita 24 hours 8 Funere etely fille		Crieck only Z Medical Examine	On the basis of examination	dge, death and/or inve	occurred at the testigation, in my	me, date and opinion, death	place, and due occurred at the	to the cause(s e time, date an	s) and manner and place, and dur	s stated. e to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  STANLEY A. SCHWARTZ 2101 MEDICAL PARK DR. #2 SIWER SPRING, NO  State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		To th within To th comp		29b. Signature and title of certifier	2 11	1				29d. Da	ate signed (Moni	th, Day, Year)
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		Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature			, ,				

DHMH 17 Rev 1/2001

ORIGINAL

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 27 orraine 19:57 2004 SNO 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hospita If Under 24 Hrs. 8. D Hours Min. 9. Birthplace (State or Foleign 5. Social Security Number If Under 1 Year 6. Sex 8. Date of Birth (Month, Day, Yea 7. Age (In yrs. last birthday) 1□ M 2□ F Months Days 13-30-886 Vrs 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Ves 2 No 10e. Street and Number 10g. Citizen of What Country? 21201 venue 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ū No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No 3 Widowed 4 □ Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) abra James 19a. Informant's Name/Relationship (Type, 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Himore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of emetery, crematory or other place) 20c. Location - City or Town, State 1 D Burial 2 □ Cremation 3 □ Removal from State 7-2-04 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility bughn C Greene Funeral 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): en in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 ☐ Yas 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? SIDNO No

**Physician** /Medical Examiner or Attending Physician: The law requires that tha daath certificata be executed

**Physician** 

/Medical

Examiner

Funeral Director

Completed by

Be

**Funeral** 

Director

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Pages 1 and 2 should be filed within 72 hours after daath with tha Maryland

Baltimore, Maryland 21215-0020

Boone, Juanita

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiena. Department of Health and Mental Hygiena. any incortant: If item 27 is marked other than "natural", or items 23a or 28a-f shou any injury or other traumatic event, if Medical Evanment must be notified at once.

Physician/Medical Examiner signad by the a þ Be Completed has re 2 s page To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag Medical Certification: To

Division of Vital Records, P.O. Box 68760,

art II. Othar significar	nt conditions contrib	uting to death but	not resulting in the u	inderlying cause give
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25. Was case referred to examiner?						26.	Place of De	eath (Check only one)			
1 ☐ Yes 2 No	Ho	ospital: 1 Inpatient 2 I	ER/Outpatient	3□	DOA	Other: 4	I□ Nursing	Home 5 ☐ Residenc	e 6 🗆 Other	(Specify)	
2 Accident	Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	М	1	njury at Work?	2 🗆 No	28d. Describe how			
3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, street, factory, office					28f. Location (Street and Number or Rural Route Number City or Town, State)			

4 Homicide	determined	building, etc. (Specify)	28f. Location (St City or Town
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29a Certifier	1 Cartifying Physi	Clan: To the heat of my knowledge, doesn accounted at the size of	

y	1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 Madical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
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29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2004

29b. Signature and title of certifier

Sina, Lucene West 2401 32. Registrar's Signature 31. Date filed (Month Day, Year)

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 8 per fh G845 7-15-05 tas trar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Brown 28 1320 2004 /Medical 4c. County of Deeth Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** Age (In yrs. last birthday).
Yrs. **Funeral** Days Months Month Day Ye 1 M 2 F -16-9150 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County treumetic event, the Medical Examiner must be notified at 1 Yes 2 No Director WD 28e-f 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō Items 23e by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cyban, Mexican, Puerto Rican, etc.) Ever in U.S. 14 Race can Indian Armed Forces? permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or Iten any injury or other treumetic event, the Medical Examinations. Black, White, etc. 2 Married 1 Never Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life_DO NOT use retired) Completed 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be tva od of Disposition Burial 2 Cremation 3 Removal from State ^ 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licer Greene Funeral onc Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Aneuro Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit Due to (or as a consequence of): the attending physician P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 Yes 2 No 3 Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes Division of Vital 2 □ **y**K To the Hospital or Attending Physicien: within 24 hours after death. To the Fureral Director: After this certified 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 1 ☐ Yes 2 ☑ No 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manger of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural
Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

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State Registrar

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Old Ct

32. Registrar's Signature

Laura Harlan

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IIIN 2 9

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5401

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Year Rosette Batleman June 20 2004 3:50PM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4209 Havard Street Wheaton Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) Months 1 □ M 2 🛛 F Director 094-28-3933 68 April 20,1936 Baghdad, Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a, State 10b. Counts 28a-f ehow 10d. Inside City Limits other treumetic event, the Medical Exercitor must be notified at Director 1 ☐ Yes 2 No Maryland Montgomery Wheaton 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? ö 4209 Havard Street items 23e 20906 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ö Specify: White 1 ☐ Yes 2 X No Specify: "netural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ent: If item 27 Is marked othar then ' ury or other treumetic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Heron Setty Nagia (unavailable) ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Rideout Court Gaithersburg, MD 20877 Batleman Alan (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State June 29,2004 Chesapeake Crematory parmit. Page Department of Importent: If eny injury or once. Beltsville, MD `4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Funeral Service Licensee 22. Name and Address of Facility Funeral And Cremation Services Gist Avenue Silver Spring, MD 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List enty one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Colon Cancer Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be axecuted burial-transit Due to (or as a consequence of): Box 68760. physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4∏Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an nas e 2 autopsy performed? page 2X No 1□ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home S Residence 6 Other (Specify) 2 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No after death Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours at e Funeral D letely fillad i 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical npletely (Check only within 2 To the To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M. D 24, 2004 woon DO 1191 JUNE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ralph Coan, M.D., 9618 Culver Street, Kensington, MD. 20895 32. Registrar's Signature 31. Date filed 101, 2ay9 2004 State Registrar

			For State Registrar	State o	of Mary	,	artment of F				iene g. No.2 ()	04	20399
	Di sisi		1. Decedent's Name (First, Middle, I	ast)					The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s	2. Date of Death	Dav	Yeer	3. Time of Death
	Physicia /Medic		Frederick	W. Beck	er					June 9,	2004		2:37 PM M
	Examin		4a. Facility Name (If not institution, g		imber)		4b. City, Town, o				4c. Count	1.77	
			1 Gorsuch 5. Social Security Number 6	Koad	7. Age (In	yrs. last birthday)	Luthe		r 24 Hrs.	8. Date of Birth		Balti	
	Funeral Director		219-18-5227	1 <b>∑</b> M 2□F		O Yrs.	Months Days	Hours	Min.	8. Date of Birth (Month, Day, Nov 25,	^{Year)} 1923		place (State or Foreign ntry) yland
<i>0.4</i> 0	ט		Usual Residence of Decedent										
	anylar	<u></u>	MD Balt	imore	100	c. City, Town or Lo	herville						0d. Inside City Limits 1 ☐ Yes 2√ No
	Ne M	Director	10e. Street and Number	IMOLE		шис	10f. Zip Code			11	og. Citizen of	What Cour	
	With Se or		1 Gorsuch	Road			10 2.0 0000	210	093	"	US US		,
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٥	be filed within 72 hours after death with the Maryland stal Hygiene.  dother than "natural", or itema 23e or 28e-f ehow event, the Madical Estiminar mant be notified at		1 Never Married 2 Married	if Yas, G	2 🗌 No	-	1 ☐ Yes 2 ☒ No	Specify		nicari, etc.)		ick, White, fy: Whi	
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ŗ	within 72   ene. than "nat	Completed	15. Decedent's (Specify only highest	grade completed,		(Give	dent's Usual Occup kind of work done DO NOT use retired	during mo	st of worki	ing	16b. Kind of B	susiness/in	austry
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and	e filed within al Hygiene. I other than vent, II a Mo	Bec	17. Father's Name (First, Middle, La							e (First, Middle, N		тө)	
<u>a</u>		To	William Freder		cer					eth Ann			
Mar	2 sho	1 1	19a. Informant's Name/Relationship				ng Address (Street						(Code)
	s 1 and 2 should f Health and Mer item 27 ie marke other treumetic		Eric Becker/so	<u>n</u>	2	Ob. Place of Dispo	Gorsuch Rosition (Name of		54.5.30		MD 21	.093 - City or To	own. State
ğ	Pages nent of int: If it iry or o		1 ☐ Burial 2 ☐ Cremation 3  4 ☑ Donation 5 ☐ Other (Spe		State	7 cemetery, crei	matory`or other plac	ce)					
Baltimore,	permit. Pages Department of I Important: If its eny injury or o		2 Signatur 1 Tarent Service 1	Wade	Men	/	2. Name and Addre ate Anat altimore,	oss of Faci	lity Board	.655 W.	Baltim	ore S	treet
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	Dharistan		shock, or heart failure. List or Immediate Cause (Final	ly one cause on	each line.	,	-					,	Interval Between Onset and Death
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8760,	cate be executed physician and the burial-transit	al E			(OI as a CO	nisequence or).							
289	ficate physis the	edical		d									
Box	eath certific attending p	ι/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, or			Ectopic pregnancy				23d. Da	ate of delive	эгу
O.	The law requires that the death certificate be executed ate has been signed by the attending physician and cage 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		nant at time		Other (specify)	y 			M	onth	Day Year
٦.	that the	, Ph	Part II. Other significant condition	s contributing to	death but no	ot resulting in the u	nderlying cause giv	en in Part	l.	23e. Did tob	acco use con	tnbute to th	ne cause of death?
ds,	w requires that been signed to should be deta	d by	Coronary	Arteri	1 DIS	erse				1 <u>☐</u> Ye	s 2 No	3 🗋 Prob	ably 4 Unknown
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	The law	mo								autopsy perform 1 Tes 2	ned2	prior to condeath?	mpletion of cause of
Vital		BeC	25. Was case referred to medical					26. Plac	e of Death	h (Check only one		10,103	20110
	Physic this ce al direc	To	examiner? 1 ☐ Yes 2 ₩ No			2 ER/Outpatier	2000	4 🗆 N	lursing Ho	me 5 Reside	nce 6 □Oth	ner (Specif	y)
Division of	ding P. h. After t	ion:	27. Manner of Death 1 ☑Natural 5 ☐ Pending		of Injury nth, Day Ye	ar) 28b. Time o	Wor	rk?		28d. Describe ho	w injury occur	rred	
SIC	death. ctor: A y the fu	icat	2 Accident investiga 3 Suicide 6 Could no	t be 380 Plac	e of Injury -	At home, farm, st		Yes 2	-	28f. Location (Str	eet and Num	ber or Rura	I Route Number
<u>&gt;</u>	after after Direct of in by	Certification:	4 ☐ Homicide determin	build	ding, etc. (S	pecify)	001, 1201017, 011100			City or Town			
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	To the within To the Somple	Me	29h Signature and title of certifier	// _/	//		29c. Licens			29	d. Date signe	od (Month)	Day, Year)
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			30. Name and address of person w	no completed car	use of death	(Item 23a) (Type,	Osler D	CIF	210	Tours	on n	nd	21204
	Sta	ate	31. Date filed (Month, Day, Year)	82.	Registrar's	Signature App	10 0 0 D	7 - 1		1000	01,11	101	1201
Į.	Regist	rar	JUN 2 9 20	04 /	a s	O GOO							

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	/Medi Examii		4a. Fecility Name (If not instit	ition, give st	- / -	17				Location		) ((1)		c. County o	f Deeth	
	Funeral Director		5. Social Security Number 569-42-2119	6. Sex	M 2□F	7. Age (In yrs	s. last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of 6 (Month, 08-21-	Birth Day, Yee -1935	⁽⁷⁾ ]	9. Birthp Cour ndia	lace (State or Foreig ntry) ana
	show	7	Usuel Residence of Deceden  10a. State 10b. Con	inty			City, Town or Lo							_	1	Od. Inside City Limits
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9036	72 hours after death with the Maryland "natural", or Itams 23a or 28a-f show idical Examinar must be inclifted at	d by Funeral Director	11. Marital Status 1 ☐ Never Married 2☑ 3 ☐ Widowed 4 ☐ Divor	Married	2. Was Deced Armed For 1 Tes : If Yes, Give Year or Da	ces? 2 <b>[2]</b> No		Was Deced f Yes, spec 1 ☐ Yes		ispanic Ori in, Mexicar Specify:	gin? (Spe i, Puerto	ecify Yes or f Rican, etc.)	No-	14. Race Black, Specify:	White,	etc.
21215-0036	c _ @	Completed	15. Dece (Specify only his Elementary/Secondary (0-1			4or 5+)	16a. Dece (Give life.	dent's Usua kind of wo DO NOT us	ol Occupa de done de de retired	ation during mos )	t of work	ing	16b. I	Kind of Busi	ness/Inc	dustry
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Maryland	b d la b	To Be	Ralph Bradfor 19a. Informant's Name/Relati	ď	e, Print)		19b. Mailir	ng Address	(Street a	Mari	orie	Nutt  Nutt		Í		Code)
Baltimore, M	fealth m 27 her tr		Doris Bradfor  20a. Method of Disposition  1  Burial 2 Cremati  4  Donation 5  Othe	on 3 ∐Re	moval from S	tate	3924 Place of Dispo cemetery, crem to. Was	natory`or o	ne of ther plac	e)		ate	20c. L	ville location - C	ity or To	•
Baltii	permit. Pages: Department of H Important: If Ite any injury or ot		21. Signature of Funeral Serv				22	. Name an	d Addres	s of Facilit	Lori	ngs By	ers	Funer	al D	irectors
			23a. Part1. Enter the disease shock, or heart failure.	, or complication	ations that ca	used the dea	0	40 L	LDer	CY KO	ad	Kandal	LSEO	wn, M	ary1	and 21133 Approximate
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8760,	icate be executed physician and s the burial-transit	Ical	resulting in death) Last	d.	Due to (o	r as a consec	quence of):									
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ords, P	The law requires that the ate has been signed by th page 2 should be detache	þ	Part II. Other significant cond	litions contr			sulting in the ur みレレA			n in Part I.		_		_	te to the	e cause of death?
Vital Record		Completed											s an opsy formed? 250No	prio	r to com	sy findings available pletion of cause of
	ysician: Th is certificate director, pag	o Be	25. Was case referred to med examiner? 1 ☐ Yes 2☐No		spital:	nationt 2	] ER/Outpatient	3 DO	Othe			(Check only				
ion of	tending Physician: leath. tor; After this certific the funeral director,	-	27. Manner of Death  Natural 5 Per	ding stigation	28a. Date of		28b. Time of Injury		c. Injury Work	at	2	ne 5 Res			Specify)	
Division	al or Attends after death	Certification:		ld not be imined	28e. Place o building	f Injury - At h	ome, farm, stre fy)	et, factory,	office	_	2	8f. Location City or To	(Street an own, State	nd Number ( 9)	or Rural	Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical (	29a. Certifier   Check only one)   Check only one)	ying Physic al Examine	ian: To the b r: On the bas and manne	is of examina	owledge, death ation and/or inv	occurred a estigation,	it the time	e, date and inion, deat	place, a	nd due to the	cause(s)	) and manne d place, and	er as sta due to t	ted. the cause(s)
	Tot Tot Com	M	29b. Signature and title of cert	tier Par	apu	MD		29c.	License )5	number 425 Ç	7			te signed (A		ey, Year)
	17		30. Name and address of pers	on who com	pleted cause	of death (Iter	m 23a) (Type, F	Print) 274 h	(CS)	Hos	PIDI	2 (61	JEN	_		
	Sta Registr		31. Date filed (Month, Day, Ye	()	32. Reg	gistrar's Signa										
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year 200-JUNE 3 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death CAND AUS TOWN SUBACUTE UNIT BALT, MORE NORTHWEST If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Director 216-34-6087 66 January 27, 1938 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or items 23a or 28a-f ehov Examinar must be notified at Maryland Baltimore Randallstown Director 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 3920 Susanna Road 21133 death United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. illed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White "natural", The Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) Churchill Distributers Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked other than College (1-4or 5+) Traffic Manager other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph Richard Beatty, Sr Cornelia Margaret Scheufele 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Lynn Beatty (Wife) 3920 Susanna Road Randallstown, Maryland 21133 June 28, 2004 Coc. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetary, crematory or other place) ö 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or * 4 Donation 5 Dother (Specify) Lake View Memorial Park Sykesville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityLoring Byers Funeral Directors Kellner M00333 8728 Liberty Road, Randallstown, MD 21133-4784 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death SEPSIS Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Completed by Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy jo in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ tinknown been s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? Yes 2/20No certificate 1 Yes 1 ☐ Yes 2 ☐ 10 Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 1 Yes 2 No 2 ER/Outpatient Nursing Home 5 Residence 6 Other (Specify) Certification: To 3□ DOA this in by the funeral 27. Manner of eath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 ANatural 5 Pending investigation Injury death 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 37333 JUNE 23, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOZ1133 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Patient Known as Binyator Manashin Baltimore, Maryland 21215-0036

	Physici		1 - State Registra AMEND ITEM  1. Decedent's Name (First, Middle, La		G832 - Ce	BINYATO	· · · · · · · · · · · · · · · · · · ·	2. Date of D Month	Day	Year	3. Time of	
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L	Funeral Director		111-31-6618	6ex, 7. A	ge (In yrs. last birthday,	If Under 1 Year   Months   Days		8. Date of B (Month, D 06/17/	1917 1917	9. Birth Con	place (State intry) RUSSI	or Foreign
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	he Ma 28a-1 e	Director	MD N/A		BALTIMOR				10a Citiza	a of Milat Car		s 2 No
	with t	וב	10e. Street and Number 6960 BROOKMILL I	DOAD ADT	1D	10f. Zip Code 21215				n of What Cou	intry ?	
	death	Funeral	11. Marital Status	12. Was Deceden			Hispanic Origin? (S pan, Mexican, Puert	pecify Yes or N		Race - Amer Black, White		
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pu	should be filed nd Mental Hygis marked other imatic event, I	Be	17. Father's Name (First, Middle, Last	)	DINV	A.T.O.V	18. Mother's Nar	ne (First, Middl	le, Maiden Su		TEV	
Maryland	2 should be and Mental is marked o	2	BENJAMIN  19a. Informant's Name/Relationship (	Type, Print)	BINY		SARA and Number or Ru	ıral Route Num	ber, City or T	SIDGE own, State, Zi		
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altimore,	g = 5		20a. Method of Disposition  1 Surial 2 Cremation 3		20b. Place of Disp cemetery_cre LIBERTY	osition (Name of matory or other pla PARK ZOIN CON(	1ce)	Date		tion - City or T		
ıltir	nit. Page vartment ortant: It injury o		<ul><li>'4 □ Donation 5 □ Other (Special</li><li>21. Signature of Funeral Service Lice</li></ul>				G 06/2 ess of Facility S0	7/2004 L LEVIN		LLSTOW		
B	permit. Departrr Importa any inju		Robert	Z	8	900 REIS	rerstown	ROAD -	PIKESV	ILLE,	MD 212	208
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68760,	ite be executed lysician and ne burial-transit	ical Examin	resulting in death) Last	C.  Due to (or a	is a consequence of):							
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Records, P.O. Box	The law requires ate has been sign page 2 should be	by	Part II. Other significant conditions	contributing to death		aridentying cause gi		24a. Wa	s an opsy formed?	24b. Were aut	opsy findings ompletion of	available cause of
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JUN 2 9 2004

State of Maryland / Department of Health and Mental Hygiene Reg. No.2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician U815A JUNE 2004 Louis Henry Branch, Jr. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LW ERSIDE LORIEN If Under 24 Hrs. If Under 1 Year Birthplace (Stete or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6 Sax **Funeral** Days Months Hours 1 3€M 2 □ F Yrs 1944 Director 215-42-9035 Maryland 60 Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-1 show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No **Funeral Directo** Maryland Harford Fallston 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1913 Parsonage Lane 21047 USA filed withIn 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Be Completed by 3 ☐ Widowed 4 ☑ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4or 5+) 10 Truck Driver Automobile Manufacturer permit. Peges 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 Is marked other any injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Elizabeth Estella Johnson Louis Henry Branch, Sr. 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1401 Harford Square Drive, Edgewood, MD 21040 Date 20c. Location City or Town, State Bruce W. Edwards / Brother Baltimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Tabernacle U.M. Chr. Cem. 6-29-04 Fallston, Maryland 4 ☐ Donation 5 ☐ Other (Specify) ²² Name and Address of Facility M. Comas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 21. Signat - o F e Service icen e 23a. P.ITI. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock, or heart failure. List only one cause on each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner Years or Attanding Physician: The law requires that the death certificeta be executed after death.

Director: After this cartificate hes been signed by the ettending physician end in by the funeral director, page 2 should be detached for use es tha bunal-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the causa of death? 1 Yes 2 DNo 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Certification: To Be Completed 2H110 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 SNursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 200No 28a. Date of injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 5 Pending investigation 1 Natural М 1 □ Yes 2 □ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or Atte within 24 hours after de To the Funeral Directo completaly filled in by the 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Yeer) 29c. License number 29b. Signature and title of certifier un 5 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) akun 32. Registrar's Signature 31. Date filed (Month, Day, Year) JUN 2 9 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** PAUL JUNE KEYSER BLACKISTON JR 2004 9:18 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Center Baltimore Towson If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) **Funeral** Days 89 Ohio Director 219-07-5802 December 5,1914 Usual Residence of Decedent the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes Director Maryland Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 2525 Pot Spring Road 21093 USA death Funeral 12, Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. If them 27 Is marked other than "natural", or flee any injury or other traumatic event Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify White Specify: à 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Engineer 12 Manufacturing 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Paul Keyser Blackiston Sr Lillian Zerkel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife 2525 Pot Spring Road Timonium Maryland 21093 Coralyn D Blackiston 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Greenmount Cemetery 6/28/04 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc. gnature of Funeral Service Dicens 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PNEUMONIA WEEKS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit certificate be executed and Due to (or as a consequence of): attending physician Box 68760 Physician/Medical the IF FEMALE: uSe a 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year for in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown 9 🗆 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsy nerformed certificate 2 No 1 Yes 1 ☐ Yes of Vital the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 2 No Other: 1 Inpatient 2 1 🔲 Yes 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Division 1 Natural 2 Accident 5 ☐ Pending investigation death. 1 Tes 2 No filled in by the Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Thomicide within 24 hours a To the Funeral C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29d. Date signed (Month. Day, Year 29b. Signature and title of certif 2 D 24034 10 30. Name and address of person who complete d cause of death (Item 23a) (Type, Print) TIMOTHY LOW. OSLER DRIVE TOWSON, MARYLAND 21204 7601 M. D 32. Registrar's Signature 31. Date filed (Month, Day, Year) JUN 2 9 2004 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

Amend Item #10b-d peatern was any 19 energing of Health and Mental Hygiene

			Amend Item #100-d	per in G	035-17	Cert	ificate o	f Death	7		Reg. No 2	104	20605
	Dhuainia		1. Decedent's Name (First, Middle, Las	1)					1	2. Dete of Dee Month	eth Dey	Year	3. Time of Death
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_)	Examine	_	4a Fecility Neme (If not institution, give	street end number	)					ation of Death	4c. Count	ty of Deeth	N/A
		ı	6600 Detroit A	venue					timo			Balt	imore Co.
	Funeral		5. Social Security Number 6. Se	x 7. A	ge (In yrs. le		If Under 1 Ye Months Day		r 24 Hrs. 8	B. Date of Birt (Month, De)	h /, Year)	9. Birth	place (State or Foreign intry)
	Director		717-07-6304	MW 20 F	94	Yrs.				July 3			yland
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	23e	<u>a</u>	6600 Detroit Av						1222			ed St	
	term term		11. Meritel Status	<ol><li>Was Decedent Armed Forces</li></ol>	?	. 13. W	es Decedent o Yes, specify C	if Hispenic O uban, <mark>M</mark> exica	rigin? (Spec an, Puerto Ri	ify Yes or No- ican, etc.)	14. Ha	ace - Ameri ack, White	ican Indian, , etc.
20	S offer	Ş L	1 Never Married 2 Married	1 ☐ Yes 2☐ If Yes, Give		1[	☐Yes 2☐XN	lo Specify	<i>/</i> :		Speci	ity:	70
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Maryland	d 2 sl th an 7 is r traul	Ť	Mrs. Marlene Krae		nter		Detro				Mary		21222
a,	Healing and 2 ther	-	20a. Method of Disposition		20b. Pla	ce of Disposi	tion (Neme of			Date	20c. Location		own. State
Baltimore,	Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Important: If Item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be invitted at other.		1 ⊠ Burial 2 □ Cremation 3 □ F			metery, creme			- 6/05	10000		•	
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	To the Hospital or Attanding Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the ettending p completely filled in by the funeral director, page 2 should be deteched for use as	2	29a. Certifier 1 A Certifying Phy	eicien: To the heet	of my knowl	edge deeth s	occurred at the	time date e	nd place so	d due to the s	alise(s) and ~	anner es	steted
	To the Hospital Within 24 hours a To the Funeral I completely filled	edicar		ner: On the basis of	of exemination								
	ithin o the		29b. Signature end little of certifier	1			29c. Lice	ense number			29d. Date sign	ed (Month,	, Day, Year)
	F 3 F 8		) Inon-	in the	1111	21	D	2 43	334		liver	78	4005
	2,5	1	20 Name and address of severe when	ompleted cause of	death /Itam 1	23a) (Tuno Di	rint)			-	June		1
	\		30. Name end eddress of person who co Thomas Finucane			opkins		71.1 Cin	cle. P	Human	MD 2	1221	1
4.	* *		31. Date filed (Month, Day, Year)		rer's Signatu		- Coy Via	w		ATT THE COPY	7500 2	166	
	State Registra		JUN 2 9 2004	100	, M.	Goal	E.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Margaret Chamberlain 2004 1:49 AM June 25 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, May 2, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 F 50 Yrs. 1954 579-68-7410 Washington D.C Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23e or 28e-f show If a Medical Executive roust be notified at Gaithersburg 1 ☐ Yes 2 No Maryland Montgomery **Funeral Director** 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 19422 Transhire Rd. 20879 United States 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry it. Pages 1 and 2 should be filed within sitment of Health and Mental Hygiene. It ent: If item 27 is marked other than injury or other treumetic event. It all Me Elementary/Secondary (0-12) College (1-4or 5+) Hair Dresser Private Salon 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Thomas W. Chamberlain, Sr. Francis Ido1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11019 Hopewell Rd., Hagerstown, MD Martin Chamberlain / Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. Chesapeake Crematory 6/29/04 Beltsville, MD 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

22. Name and Address of Facility
Rapp Funeral and Cremation S
933 Gist Ave., Silver Spring
23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 2 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician car diogenic /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a sonsayuansa or) The law requires that the death certificate be executed burial-transit attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 menths? 4☐ Pregnant at time of death 5 Other (specify) Yes the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? diso ose 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2□ No 1 TYes To the Hospitel or Attending Physicien: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 27. Manner of Ceath filled in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifiel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D058510

Registrar
DHMH 17 Rev 1/2001

State

Stephen

31. Date filed (Month,

onth, Day, Year)

2001 Medical Parkway, Annapolis, MD

ss of person who completed cause of death (Item 23a) (Type, Print)

AAMC. 2001 Me

32

**B**gistrar's Signature

			State of Maryland / Department of Health and	Mental Hyg	iene	
			1 - State Registrar Certificate of Death		eg. No. () () (	20407
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Deat Month	Day Year	3. Time of Death
	/Medic		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Dea	June	4c. County of Deal	4- 10:15 AM
1	Examin	ier	7952 CASTLE Hedge Dell Rd Glen Burni	1	ANNE	ARUNDEL
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min		9. Bir	hplace (State or Foreign
	Director		Usual Residence of Decedent	Apr. 2"	1,1931	W, $V$ .
	land low		10a, State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	a-f sh	ctor	MD. ANNE Arundel Glen Burnie			1 ☐ Yes 21⁄2 No
	or 28	Director	10e. Street and Number 10f. Zip Code	10	0g. Citizen of What Co	
	e 23a	erai	7952 Castle Hedge Dell Road 21061  11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (5	Specify Ves or No-	United S	
(0	r Item	Funeral	Armed Forces? tf Yes, specify Cuban, Mexican, Puer  1 □ Never Married 2 □ Married 1 □ Yes 2√2 No	nto Rican, etc.)	Black, Whit	e, etc.
21215-0036	72 hours after death with the Maryland naturel', or Iteme 23a or 28a-f show dical Examiner must be notilised at	d by	3 Vidowed 4 □ Divorced If Yes, Give Year or Dates:		Specify:	White
5-0	"natu	iete	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of wo	orking	16b. Kind of Business	findustry
12	filed within Hygiene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)  8  Finance		Federal G	overment
b	be filed ital Hygi id other event, II	BeC		me (First, Middle, M	Maiden Sumame)	
ylaı	should be and Mental is marked o	To		E. Sieber		
Maryland	12 sh h and 7 Is m treum		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or R  Gail Storm Dowling - Daughter  4305 Ventura Drive II		City or Town, State, 2, TN 37938	Zip Code)
	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene if Health and Mental Hygiene item 27 is marked other then "nature!", or fleme 23a or 28a-f show item 27 is marked other then."		20a. Method of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or	Town, State
altimore,	0 0		1 A Burgal 2   Cremation 3   Hemoval from State	0/04 E	lkridge, M	aryland
alti	permit. Pag Department Importent: I any Injury o		21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Cary L. Kaufman Fun	neral Home	e At MMP	Inc
8	205 2		7250 Washington Bly	vd. Elkr	idge, Mary	land 21075
			23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	ic or respiratory arre	st,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)  Due to (or as a consequence of):	TID	10212	4 years
	Examiner		Coron ara Artery	Disea	se	15 years
	gi gi	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	-		
-	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last Due to (or as a consequence of):			
8760	The law requires that the death certificate be executed to has been signed by the attending physician and age 2 should be detached for use as the burial-transit					
68	rtificate ng phys as the	Medi	IF FEMALE:			
Вох	leath certific attending pl	Physician/Medical	23b. Was decedent pregnant  1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date of del Month	ivery Day Year
0	that the de ed by the a detached f	ysic	1   Yes 2   No 9   Unknown			
, P.O	res that th igned by be detac	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
ecords,	w require been sig should b			1 X Ye	s 2□No 3□Pr	obably 4 □Unknown
ecc	e law re has be je 2 shi	Completed		24a. Was an autopsy	prior to d	topsy findings available completion of cause of
E B	(0			perform 1 ☐ Yes 2	ned2 death? X No 1 ☐ Yes	2 No
of Vital	Physiclen: r this certific ral director,	o Be	25. Was case referred to medical examiner?  1   Yes   No	eath (Check only one	nce 6 □Other (Spec	264
1 0	ding Physiclen: h. After this certific funeral director,	n; To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	28d. Describe ho		ony)
Sior	tendin leath. tor: Afi the fur	catio	2 Accident investigation M 1 Yes 2 No			
Division	or Att	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Str. City or Town,	eet and Number or Ru , State)	ral Route Number,
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place	e, and due to the ca	use(s) and manner as	stated.
	n 24 h	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence and manner stated.	urred at the time, da	te and place, and due	to the cause(s)
	withi To th	Σ	29b. Signature and title of certifier  29c. License number		d. Date signed (Month	•
	14		MUKIDUNDW/WV 17005400	25	06-28	04.
	1 "		30. Name and address of person we completed cays of death (Itel 20a) (Type, Print) 8601 Veteral Mary Beth GroTZ, DiO, Millers	ins Hwi	10 21105	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \
	Sta	te		7,110) 11	17 91100	-
	Registr	-	JUN 2 9 2004  32. Registrar's Signature			

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					State of IV	iai yiai i	•			Death	ivieritai i iy	Reg. N6)	ΩI.	201.00
	Diversion		1. Decedent's Name (First	Middle, Las	it)						2. Date of De	eath - Day	Year	3. Time of Death
*	Physicia /Medica		Jarı	ciett			Clar	ck			Month		004 ^{Year}	2:45a
- A	Examine		4a Facility Name (If not ins Future Can			r)			4	b. City, Town, or Balti		th 4c. Coun	y of Death NA	
	Funeral Director		5. Social Security Number 579–38–6746		I	ige (In yrs. 73	last birthday) Yrs.	If Unde Months	Days	If Under 24 Hrs Hours Min.		irth 26-30	9. Birthp Cour Wash	place (State or Foreign htry)
	pue *	-	Usual Residence of Deced 10a. State 10b. 0	ent County		10c. Cit	y, Town or Lo	cation					1	0d. Inside City Limits
	8a-f sho	ctor	Md.	NA			Balti				T			1 d Yes 2 □ No
	th with th	a Dir	10e. Street and Number 2848 Potee	Stree	t			10f. Zij	Code 21	225		10g. Citizen of US		itry?
020	permit. Peges 1 and 2 should be filed within 72 hours efter death with the Meryland Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "nature!, or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evanirar must be notified at once.	Completed by Funeral Director	11. Marital Status  1 Never Married 2[ 3 Widowed 4 Di		12. Was Deceden Armed Forces 1 🛣 Yes 2 🗀 If Yes, Give Year or Dates	? ] <b>N</b> o				ispanic Origin? (S in, Mexican, Puer Specify:	Specify Yes or Note Rican, etc.)	o- 14. Ra Bli Speci	ce - Americack, White,	
Maryland 21215-0020	within 72 ho	mpieted	(Specify only Elementary/Secondary (		ucation de <i>completed)</i> College (1-4or	5+)		kind of wo DO NOT u	ork done d ise retired	ation during most of wo carded	rking	D.C. c	f Col	umbia
<b>d</b> 2	be filed with ntal Hygiene. id other than event, the	ဒ္ဓ	12th grade  17. Father's Name (First, A	fiddle, Last)			PLO	рошк	u ket	18. Mother's Na	me (First, Middle			L •
an	ould be i Mental I erked of	To Be	James	,,		Cla	rk			Luven	ia	Was	hingt	on
ary	2 should and Men Is marke aumetic	-	19a. Informant's Name/Re	lationship (7	ype, Print)		19b. Mailin	ng Addres	s (Street	and Number or Ri	ural Route Numb	ber, City or Town	, State, Zip	Code)
	1 and 2 Heelth a em 27 is other trai		Michelle L.	Clar	k Wif					reet, B	altimore	e, Md.	21225	
Baltimore,	permit. Peges 1 and Department of Heelth Important: If Item 27 any Injury or other to once.		20a. Method of Disposition 1 Burial 2 Crem 4 Donation 5 Of	ation 3 🗆		C	Place of Dispo emetery, cren "rison	natory or o	other plac	et Cem.	7-2-04	20c. Location Owin		lls, Md.
Balt	permit. Departr Imports any inj		21. Signature of Funeral S	ervice Licen:	500 / 2Ge	44				ss of Facility  East		ltimore, E. North		21202
		1	23a. Part1. Enter the diseashock, or heart failure	ase, or comp	ations that cause one cause on each	the deat	Do not ent	er the mod	de of dyin	g, such as cardia	c or respiratory a	arrest,	1	Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)		a					asiulu	~ au	edent		Configuration Configuration
4		<u>ē</u>				Due to (o	r as a conseq	uence of)	•				1	
,	executed n and ial-transit	edical Examiner	Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or injury that initiated events		b	Due to (o	r as a conseq	uence of):	:				1	
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Box	endin r usa	32			d									
	he ett	Physician/	Part II. Other significant co	onditions co	ntributing to death	but not resi	ulting in the ur	nderlying	cause give	en in Part I.	23b. Did	tobacco use c	ontribute to	the cause of death?
s, P.O.	iras that tha daath cert signed by the ettendin d ba dateched for usa	Dy Pa			Surjue	a	lisord	'es		·-	1 🗆	Yes 2□ No	3 ☐ Prot	pably 4 Unknown
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æ	sician: The law certificate has b director, page 2 s	E									1U	Yes 2ENu	10	]Yes 2□No
ital	lan: T	en l	25. Was case referred to n	nedical			4				ath (Check only	one)	1	
n of Vital	ng Physic fler this ce maral dire	2	1 ☐ Yes 2 ☑ No 27. Manner of Death	Pending	Hospital: 1 ☐ Inpat 28a. Date of Inj (Month, D		ER/Outpatien 28b. Time of Injury	1	28c. Injun Worl	at k?	lome 5 ☐ Resi 28d. Describe	idence 6 🗆 Ot how injury occu		)
Division	or Attending frar death. Mrector: After in by the funa	mincati	3 ☐ Suicide 6 ☐ 6	nvestigation Could not be determined	Zoe. Flace of II	njury - At ho	ome, farm, stre	M eet, factor		Yes 2□No		(Street and Num wn, State)	ber or Rura	I Route Number,
ш	To the Hospital or Attending Physicien: The I within 24 hours effer death. To the Funeral Director: After this certificate he complately filled in by the funeral director, page	edical Certification;			rsician: To the best iner: On the basis and manner s	of examinat								
_	Vithin Fo the sompl	E	29b. Signature and title of	ceptifier	_				c. License			29d. Date sign		
			1	T	mo				172	7565		6/2	6/04	
	3		30. Name and address of p	prison who o	ompleted cause of	death (Item	23a) (Type,	Print)	183	8 Gre	eno	Tres	Ros	1 21208
	State Registra	-	31. Date filed (Month, Day, JUN 2			trar's Signa		R. D						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician JUNE 23,2004 SUE ELIZABETH COLEMAN рм 6:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 16758 GORSUCH MILL ROAD **UPPERCO** BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | OCT . 04 , 1945 5. Social Security Number 539-48-1623 6. Sex Funeral 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 58 1 M 2 XF Yrs Director IOWA Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Locatio 10d. Inside City Limits
1 ☐ Yes 2 ☐ No 7 is marked other than "natural", or itame 23a or 28a-f show traumatic event, the Medical Examinar must be notified at MD BALTÍMORE UPPERCO Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 16758 GORSUCH MILL ROAD 21155 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be fited within 72 hours after to Department of Health and Mental Hygiene. Insportant: If item 27 is marked other than "natural, or item any injury or other traumatic access. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NURSE NURSING/ MEDICAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)
DORIS YOUNG Be GEORGE MANUSSIER ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PETER COLEMAN husband 16758 GORSUCH MILL RD. UPPERCO, MD. 21155 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State WHITE HALL, MD WISEBURG COMCERY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HENRY of Funeral Service Licensee W. JENKINS & SONS CO. ONBO 16924 YORK RD. MONKTON, MD. 21111 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final Envsician a Adenocercznomy of the disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical as the t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 No Month Year Day 4☐Pregnant at time of death 5 Other (specify) Records, P.O. the t detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate of Vital 1 Yes 2**X** No 1 Yes 2 No To the Hospitei or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🕱 Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Yes 2 📉 No P 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28d. Describe how injury occurred After Certification; Division 1 X Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \( \tag{Homicide} within 24 hours a To the Funeral C completely filled 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Medi DIRECTOR, DIVISION 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) of Medical orcolog and address of person who completed cause of death (Item 23a) (Type, Print) KOSS BALTIMONES DONE 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar JUN 2 9 2004

			1 - For State Registrar	State of Maryla	nd / Depa			lental Hygie		20410
1	Observation		1. Decedent's Name (First, Middle, La	ist)	<u>-</u> .			2. Date of Death		3. Time of Death
	Physic /Medi		Ronald Jo	seph Carte	r			June 18	Day Year	4:04 P M
	Exami		4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town, or	r Location of Death		4c. County of Deat	
			279 Roesler Aven	ue		Glen Bu	rnie		Anne Aru	ınde1
	Funeral				. last birthday)	If Under 1 Year Months Days	if Under 24 Hrs. Hours Min.	8. Date of Birth		hplace (State or Foreign untry)
	Director		212-34-2382	1 <b>X</b> M 2□ F 66	Yrs.	Wiorians Days	Hours Min.	8. Date of Birth (Month, Day, Ye 7/30/193	7	D.C.
	and *		Usual Residence of Decedent  10a. State 10b. County	100 C	ity. Town or Lo					
	sho	5	MD Anne Ar		n Burn					10d. Inside City Limits
	n the Marylan r 28a-f show notified at	ecto		dide1 Gie	II DULII		- 11			1 ☐ Yes 2X No
	with t	Ö	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Co	untry?
	72 hours after death with the Maryland naturel', or Items 23a or 28a-1 show Jical Exartrust te notified at	by Funeral Director	279 Roesler Aven			21061			USA	
	er de Item	nu	11. Marital Status	12. Was Decedent Ever in L Armed Forces?	J.S. 13.	Vas Decedent of H f Yes, specify Cuba	ispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
36	rs aff	y F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2X No If Yes, Give		I□Yes 2X No	Specify:		Specify: wh	
Ö	"natural",	edk	15. Decedent's E	Year or Dates:	160 Dagg	lastic Name Comm				
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12	with ene. ther	mc	Elementary/Secondary (0-12)	College (1-4or 5+) 5+	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Pastor	"		Church	
9	filled Hygi sther	Ö	17. Father's Name (First, Middle, Last			Tastor	18 Mother's Name	(First, Middle, Maid		
an	d be antai	o Be	Frank Joseph Ca					May Satte	,	
2	should Me Me mark	ြ	19a. Informant's Name/Relationship		10h Mailis	a Address (Chront				
Maryland 21215-0036	d2s thar trau	1 8	Mrs. Linda Carter				and Number or Rura e. Glen B			ip Code)
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Baltimore,	permit. Pages 1 a Department of Hearm Important: If item any injury or othe 2008.		4 ☐ Donation 5 ☐ Other (Special 21. Six ature of Fix er al Service vice)		-	Pa	rk			
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п			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the dear	h Do not ente	or the mode of dying	g, such as cardiac o	r respiratory arrest,		Approximate
	Physician	Š 1,	Immediate Cause (Final disease or condition		reatie	Can w-				Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a consec		CHWICO				20 200
ı,	Examiner		Conventially list and data	h						
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	The law requires that the death certificate be executed the has been signed by the attending physician and agge 2 should be detached for use as the burial-transit	Examiner	triat initiated events	C						
o,	e exe ian a urial-		resulting in death) Last	Due to (or as a conseq	uence of):					
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99	eath certifica attending ph for use as t	Med	IF FEMALE:							
Вох	tendi tendi	an/l	23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	_	Ectopic pregnancy			23d. Date of deliv	ery
). E	ed fo	sici	in the past 12 months?  1 Yes 2 No	4 Pregnant at time of d		Other (specify)			Month	Day Year
P.O.	that the de led by the a detached f	hy	9 Unknown							
Ś	iw requires that been signed b should be deta	by	Part II. Other significant conditions of	ontributing to death but not res	ulting in the un	derlying cause give	n in Part I.	23e. Did tobacc	o use contribute to t	he cause of death?
ord	equir en s ould	Completed						1 ☐ Yes	2 No 3 Prot	oably 4 Unknown
S	aw r as be 2 sh	pie						24a. Was an	24b. Were auto	ppsy findings available
ď	The his page	E						autopsy performed?	prior to co death?	mpletion of cause of
ita	sician: The law certificate has b irector, page 2 s	0	25. Was case referred to medical				26. Place of Death	(Check only one)	√o 1 ☐ Yes	2 No
of Vital Records,	Physician: r this certifica ral director,	ToB	examiner? 1 ☐ Yes 2 ► No	Hospital: 1 Inpatient 2 I	ER/Outpatient	3 DOA Othe		e 5X Residence	6 DOthor (Cassid	
0	ding Ph n. After th funeral		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injury Work		8d. Describe how in		y)
0	Attendin death. ctor: Aft y the fur	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury		? 'es 2 □ No			
Division	Atte	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	286. Place of Injury - At ho	me, farm, stre	et, factory, office	28	Bf. Location (Street	and Number or Rura	al Route Number.
Ö	al or	Sert	4 🖂 Hornidge	building, etc. (Specify	/)			City or Town, Sta	te)	
	spit hours mera y fille		29a. Certifier 1 Certifying Ph	ysician: To the best of my kno	wledge, death	occurred at the time	e, date and place, ar	nd due to the cause	s) and manner as s	tated
	or the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edicai	(Check only 2 Medical Examone)	niner: On the basis of examina and manner stated.	tion and/or inv	estigation, in my opi	inion, death occurred	d at the time, date a	nd place, and due to	the cause(s)
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29b. Signature and title of certifier			29c. License	number	29d. C	ate signed (Month,	Day, Year)
•				11		D	50108		6/22/20	04
	C	-	30. Name and address of person who	completed cause of death (Item	23a) (Type, F		0 - 1 0 0		- 1 - 1 -	1
	X		Michael Down	•		Load Suit	لو 200 (6	ter funna	MD 21	561
	Sta	te	31. Date filed (Month, Day, Year) JUN 2 9 2004	32. Registrar's Signa		rock		A - 1 11 -4 111	- 1	
	Registra	ar	JUN Z 3 ZUU4	La Trans	pop	our				

Anthony Joseph Ditch Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-04168 State of Maryland / Department of Health and Mental Hygiene cm1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** ANTHONY JOSEPH DITCH 25 2004 3:15 June /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel 120 Glenlea Drive Glen Burnie If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex .^Y°¶960 **Funeral** 1 XM 2 F 43 MARYLAND 216-78-3425 Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene.

Hydiene. "natural", or Items 23s or 28a-f ehow 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State s 23s or 28a-f ehow 1 ☐ Yes 2 No GLEN BURNIE MARYLAND ANNE ARUNDEL Director 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 21060 120 GLENLEA DRIVE UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 100 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1980-Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏖 No Specify: 1982 Specify: WHITE þ 3 ☐ Widowed 4 ₹ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION MASONARY 12 and Mental Hygie Is marked other! permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Importent: If Item 27 Is marked othe any injury or other treumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be BURNELL A. DITCH PATRICIA C. GORDON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BURNELL A. DITCH / FATHER GLEN BURNIE, MD 21060 120 GLENLEA DRIVE 20b. Place of Disposition (Name of JUNE 29. 20c. Location - City or Town, State 20a Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donaytion 5 ☐ Other (Specify) CROWNSVILLE MD VET. CEM. 2004 CROWNSVILLE, MD 21. Signature of Funeral Service Licensee KIRKLEY ARUDDICKY FUNERAL HOME P.A. 421 CRAIN HWY. S.E. GLEN BURNIE, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) GASTROINTESTINAL Physician BIEEDING /Medical Due to (or as a consequence of): Examiner OF 1RRHOSIS Teh= Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. attending physician Physician/Medlcal as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. the 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records. 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death.

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? certificate Yes 2 No or Attending Physicien: 25. Was case referred to medical examiner?
1 ∠Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other:  $4 \square \text{ Nursing Home } 5 \square \text{ Residence } 6 \ \square \text{Other } \text{(Specify)} \text{at scene}$ Certification: To ierel Director: After the filled in by the funeral 28b. Time of 28d. Describe how injury occurred Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide within 24 hours a To the Sunerel L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signat or and title of certifier

31. Date filed (Month, Day, Year)

JUN 2 9 2004

32. Registrar's Signature

(M)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

June 26, 2004

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month Day **Physician** Margarita Katharina Dobert June 25 2004 12:00 a^M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 5124 Wissioming Road Bethesda, MD Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🖸 F 94 Yrs. 19, Director 579-30-2931 Jan. 1910 Turkey Usual Residence of Decedent 10c. City, Town or Location 10a, State 10d. Inside City Limits 10b. County "neturel", or Items 23a or 28e-f show 1 ☐ Yes 2 ☑ No Montgomery Bethesda Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5124 Wissioming Road 20816 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2F No If Yes, Give Year or Dates: 1 ☐ Never Married 2 → Married 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) College (1-4or 5+) other than Elementary/Secondary (0-12) Private Writer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be 1 Mental I is marked Aristoteles Siniossoglu Marata Reiche 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stefan Dobert/Son f Health item 27 471 Fairhaven Road, Tracys Landing, MD 20779 other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Importent: If ite
any injury or ot
once. 1 ☐ Burial 25 Cremation 3 ☐ Removal from State June 29, Beltsville, MD 4 □ Donation 5 □ Other (Specify) Chesapeake Crematory 2004 22. Name and Address of Facility Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 20910 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metastatic Adenocarcinoma of the colon to the liver disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): ner Cause (Disease or injury Exam nding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 No Month 4☐Pregnant at time of death 5 Other (specify) tached 9 Unknown 8 signed I det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2X No page 2 certificate 1 Yes 2 XNo director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: P 1 Yes 2 XNo 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) After th funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after deatl 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical pletely (Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of D35579 June 26, 2004 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Susan J. Miller, M.D., 6844 Tulip Hill Terrace, Bethesda, MD 20816 31. Date filed (Month Ray) 3 Registrar's Signature State 2004 Registrar

DHMH 17 Rev 1/2001

filed within 72 hours after death

The law requires that the death certificate be executed

P.O. Box 68760.

Division of Vital Records,

Baltimore, Maryland 21215-0036

			For State Registrar	-	epartment of Health and No		ene 
			Decedent's Name (First, Middle,			2. Date of Death	3. Time of Death
	Physici		Adele V.	Dolgos		June 28,	2004 Year 5:30 A ^M
1	/Medio Examir		4a. Facility Name (If not institution,		4b. City, Town, or Location of Death		4c. County of Death
4			10316 C Malcol	m Cir.	Cockeysville		Baltimore
	Funeral		5. Social Security Number 6	S. Sex 7. Age (In yrs. last birth	Months Days Hours Min.	8. Date of Birth (Month, Day, Y	
	Director		067-16-8146	1□M 2\ F 81 Y	S.	July 7,	1922 New York
	pue M		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location		10d. Inside City Limits
	Aarylan F show	5			, 1 1		1 ☐ Yes 2X No
	28a-	Director	MD Balt  10e. Street and Number	imore Cockey	SV111e 10f. Zip Code	100	. Citizen of What Country?
	with Sa or	٥		olm Cir.	21030		
	ns 23	era	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	Decity Yes or No-	USA 14. Race - American Indian,
(0	r iter	Funeral	1 Never Married 2 Marrie	Armed Forces? 1 ☐ Yes 2 🛣 No		o Rican, etc.)	Black, White, etc.
93	ai', o	b	3 ∰Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 🎇 No Specify:		Specify: White
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or items 23a or 28a-f show ovent, I'm Medical Exacti at mast be notified at	Completed	15. Decedent's (Specify only highest		ecedent's Usual Occupation Give kind of work done during most of work	kina 16	b. Kind of Business/Industry
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Maryland	d ta b	Be	17. Father's Name (First, Middle, La			ne (First, Middle, Ma	
3	d Mer narka	은	Michael Stanis		Alexan  Mailing Address (Street and Number or Ru.	dria Szcz	
Ma	12 st h and 7 is n traun		19a. Informant's Name/Relationshi				
	ges 1 and 2 should tof Health and Men If item 27 is marks or other traumatic	1	Arlene Das/Dau 20a. Method of Disposition	20b. Place of D	isposition (Name of	kton, MD	ZIIII c. Location - City or Town, State
٥	Pages nent of thant: If ite		1 Burial 2 Cremation 3		Valley July	2,	•
Baltimore,	permit. Pages 1 and 3 Depertment of Health Important: If item 27 any injury or other tru once.		' 4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service ☐	remoria	1 Gardens 20 22. Name and Address of Facility	04	Timonium, MD
Ba	permit. Depertu Importe any inju		1400	Michael J. Flagle	Lemmon Funeral Hom 10 W. Padonia Road		
			23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that caused the death. Do no any one cause on each line.	t enter the mode of dying, such as cardiac	or respiratory arrest	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	a VENJIZICHLA	R DYSRITY MAY	119	MINS
	/Medical Examiner		resulting in death)	Due to (or as a consequence of	122400 0		
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	and al-trar	xan	that initiated events resulting in death) Last	c Due to (or as a consequence of	:		
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687	ficate phy: s the	edicai		<b>Q</b> ,			
Вох	death certificate be executed e attending physician and of for use as the burial-transit	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy	-0-101		23d. Date of delivery
ă	d for	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 2□Fetal death 4□Pregnant at time of death	3 Ectopic pregnancy 5 Other (specify)		Month Day Year
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Œ.	The law requires that the site has been signed by the bage 2 should be detache.	by P	Part II. Other significant condition	s contributing to death but not resulting in t	he underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?
rds	quire en sig	edt				1 🗌 Yes	2 No 3 Probably 4 Unknown
Vital Records,	aw requisible been 2 should	Completed				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
æ	The lay	E				performe	death?
ita		Bec	25. Was case referred to medical examiner?		26. Place of Deal	th (Check only one)	
of V	S S	2	1 Yes 2 1 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp	atient 3 DOA Other: 4 Nursing Ho	ome 5 Hesideno	e 6 Other (Specify)
			27. Manny of Death 1 D atural 5 □ Pending	28a. Date of Injury (Month, Day Year) 28b. Tin	ne of 28c. Injury at	28d. Describe how	
0	death.	catio	2 Accident investiga		M 1 Yes 2 No		
Division	fter Sire	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		n, street, factory, office	28f. Location (Stree City or Town, S	at and Number or Rural Route Number, State)
	To the Hospital or At within 24 hours after of To the Funaral Direct completely filled in by		29a. Certifier 12 Certifying	Physician: To the best of my knowledge,	death occurred at the time, date and place,	and due to the caus	se(s) and manner as stated.
	• Ho • Fur • Fur • Fur	Medical	(Check only 2 Medical Exone)	caminer: On the basis of examination and/	or investigation, in my opinion, death occur	red at the time, date	and place, and due to the cause(s)
	Vithin Fo th	Me	29b. Signature and kitle of continer	$\Omega / I$	29c. License number		Date signed (Month, Day, Year)
			▶ ///// (	1101	DOOG 560	2	6 28 49
	10		30. Name and address of person w	no completed cause of death (Item 23a) (T	/pe, Print)		
	,		Dr. Richard Bi	ggs 7505 Osler Dr.	Suite 103 Towson	, MD 2120	4
	Sta	_	31. Date filed (Month, Day, Year)	32. Registrar's Signature	Spark		
	Registi	rar	JUN 2 9 2004	Warmen 10	spouls!		

State of Maryland / Department of Health and Mental Hygiene

			Certificate of Death		Reg. No. (2)	01.	20111
	Physicia	an	1. Decedent's Name (First, Middle, Last)  ME(V/N)  DARNEC(	2. Date of Do Month	eeth Day	Year	3. Jime of Death
No.	/Medic	al	4e Fecility Neme (If not institution, give street end number)  4b. City, Town, or Lo	ocation of Deat	th 4c. County	of Death	UP
1	Examin	er	Catonsville Commons Nursing Home Catonsvi			imore	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) If Under 1 Year If Under 24 Hrs.	8. Date of Bi			ace (State or Foreign
	Director		212-03-1024 LSJM 2LJF 92 Yrs.	April	12,1912		yland
	end **		Usuel Residence of Decedent  10a. Stete 10b. County 10c. City, Town or Location			10	Od. Inside City Limits
	Mary Fehr	ţ	Maryland Baltimore Baltimore				1 ☐ Yes 2XXNo
	or 188	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of V	What Count	ry?
	th wil		7512 Westfield Road 21222		U.S.	Α.	
	r dear	Funerai	11. Maritel Status  12. Wes Decedent Ever in U,S. Armed Forces?  13. Was Decedent of Hispenic Origin? (Specific Yes, specify Cuban, Mexican, Puerto	acify Yes or No Rican, etc.)	lo- 14. Rac Blac	e - America ck, White, e	
Maryland 21215-0020	72 hours after death with the Marylend "natural", or itema 23a or 28a-f show edical Examiner must be notified at	þ	1⊠ Never Merried 2 □ Married 1 △ Yes 2 □ No H Yes, Give WW II 1 □ Yes 2⊠ No Specify: Year or Dates: WW II		Specify	. Wh	ite
5-0	72 ho	Completed	15. Decedent's Education (Specify only highest grede completed)  16a. Decedent's Usual Occupetion (Give kind of work done during most of workiil life. DO NOT use retired)	ing	16b. Kind of Bu	usiness/Ind	ustry
121	within then.	mpi	Elementery/Secondary (0-12) College (1-40r 5+)		<b>T</b>		
<b>d</b> 2	Hyg Hyg		12 Salesman  17. Fether's Neme (First, Middle, Last) 18. Mother's Name	ə (First, Middle	Insura e, Maiden Sumem		
lan	\$ E & >	To Be		Swane			
ary	₽ E E		19a. Informent's Neme/Relationship (Type, Print)  19b. Mailing Address (Street end Number or Rure			Stete, Zip	Code)
	and 2 ealth e n 27 is		Gary Gregory (Nephew) 7215 Westfield Road Ba				
ore	Pages 1 nent of H nt: If Iten iry or oth		20a. Method of Disposition  1XS Burial 2 □ Cremation 3 □ Removal from State  20b. Place of Disposition (Name of cemetery, cremetory or other place)	Date	20c. Location -	City or Tow	vn, State
Baltimore,	ertmen ertmen ortant: Injury		4 □ Donation 5 □ Other (Specify) Woodlawn Cemetery 6	-29-04	Woodlaw	n, Ma	ryland
Bal	permit. Page Depertment Important: If any Injury or ance.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Witzke Funeral Home	of Ca	tonsvill	e, In	С.
_			232 Red 1 Feter the disease or complications that several the death. To not onto the mode of drive such as conditions	ue_Cat	onsville		21228 Approximate
4	Physician		23e. Pert1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such es cardiac o shock, or heart failure. List only one cause on each line.	n respiratory a	arrest,		Interval Between Onset and Death
1	/Medical		Immediate Cause (Final disease or condition				Juseks
	Examiner		resulting in death)  Due to (or es e consequence of):				3.0367
	D .₩	iner					
	rtificate be executed ng physicien end s as the bural-trensit	Examiner	Sequentially list conditions, if any, leading to immediate				
68760,	be eg	aiE	Sequentially list conditions, if ery, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events				
687	artificate ing phys e as the	edicai	resulting in deeth) Lest  Due to (or as e consequence of):			1	
Box		<b>2</b>	d				
	as that tha daath ce igned by tha attandi be datached for use	Physician/	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did	tobacco use cor	ntribute to	the cause of death?
P.0	requiras that tha teen signed by th hould be datache	Ph	1)ementa	1 🗆	Yes 2□No	3 Probe	ably 4 Unknown
	iras th signed d be d	۾	J.Serritorii (	04.146		Odb Wo	re autopay findings
Ö	v require been si should I	eted			s an autopsy ormed?	avai	re autopsy findings ilable prior to apletion of cause
Rec	e lav has ge 2	Completed			<b>L</b>		eeth?
Ta I	i <b>cian</b> : The la certificate ha rector, pege		25. Was cese referred to medical 26. Place of Death		Yes 2 No	1 🗆	Yes 2. No
of Vital Records,	Physician: this certific	To Be	examiner?		idence 6 □Oth	er (Specify	,
100	g Phy er this		27. Menner of Death 28a. Date of Injury 28b. Time of 28c. Injury et 2		how injury occurr		
Sior	Attending I ir death. octor: After by the funer	atic	2 Accident investigation M 1 Yes 2 No				
Division	or Attendent efter deatl Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)		(Street and Numb own, State)	er or Rurel	Route Number,
0	pital o		29a. Certifier 1⊈ Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, e				
	To the Hospital or Attending Phywithin 24 hours efter death.  To the Funeral Director: After thi completely filled in by the funeral	edicai	29a. Certifying Physician: To the bast of my knowledge, deeth occurred at the time, date end place, e (Check only one)  1				
_	within To the	Me	29b. Signature end file of certifier 29c. License number		29d. Date signed		
			Du AGUNDING PHYSIEVEN US364	S	June	28	2006
	3	-	30. Name and address of person who completed cause of death (Item 23e) (Type, Print)  XHOUTOU 560hoch Raven Blud;	2. 3	DAL	4	0/220
	/			212	DUTTI	nsil	2165/
	Stat Registra		31. Date filed (Month, Dey, Year)  32. Registrar's Signature				

DHMH 16 Rev 6/95

**Physician** 

**Funeral** 

Director

item 27 is marked other than "natural", or items 23a or 28e-f sho other traumatic event, the Medical Examinar must be notified at

and Mental Hygie

Pages 1 and 2 should be f nent of Health and Mental H ent: If item 27 is marked of

ö

Physician /Medical

Examiner

burial-transit

use as the

ò

detached

Physician/Medicai

Be

Medicai

State

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

/Medica Examine

10a State

Direct

Completed by Funeral

. For	State of	of Maryland	d / Depa	artmen	t of H	ealth a	and M	lental Hygi	iene
1 - State Registrar			Cei	rtificat	e of L	Death		Re	g. No,
1. Decedent's Name (First, Middle,	, Last)	-						2. Date of Death	
Ronald Winfie	eld Drewe	n Sr.						Tune	22
4a. Facility Name (If not institution,	give street and nu	mber)		4b. City,	Town, or	Location	of Death		4c.
North Arunda	azoH 15	ital		Gler	Bu	nnie			R
5. Social Security Number	6. Sex	7. Age (In yrs. la	st birthday)			If Under		8. Date of Birth	Vess
214-46-0506	1 AM 2□F	56	Yrs.	Months	Days	Hours	Min.	Jul 28,	19
Usual Residence of Decedent									

10h County

17. Father's Name (First, Middle, Last)

		,	June	22 S	1894 1894	11:40	<b>P</b> , M .
4b. City, Town	, or Location	of Death	-	4c. County	of Death		
Glen I	sinne	_		Anne	Ara	ndel	
If Under 1 Yea	r If Under	24 Hrs.	8. Date of Birth			lace (State or	Foreign
Months Day	s Hours	Min.	Jul 28	, 1947	PA	ntry)	

	•								
MD	Anne Arı	ındel	Gambri	11s					1 □ Y
10e. Street and Num	nber			10f.	Zip Code		10g. (	itizen of What	Country?
1554 Sap	pington I	rive			21054		υ.	S.A.	
11. Marital Status  1  Never Marrie 3  Widowed	ed 2 <mark>M</mark> Married 4 ⊡Divorced	12. Was Decedent Eve Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates:	r in U.S. 1		s 2 🔀 No	panic Origin? (Specify Yes o , Mexican, Puerto Rican, etc. Specify:	No-	14. Race - A Black, W Specify:	merican Indian hite, etc. white

10c. City. Town or Location

15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Project Manager Telecommunications

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Arthur Vernon Drewen, Sr. 19a. Informant's Nama/Relationship (Type, Print)

nal Se Vice Licensee

Doris Irene Pendleton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Mrs. Estelle C. Drewen / wife 1554 Sappington Drive, Gambrills, MD 21054 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Other (Specify) 4 Domation Maryland Veterans

Jun 28,2004 Crownsville, MD

mo1120 28a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

22. Name and Address of Facility Singleton Funeral Home P.A. 1 Second Avenue S.W., Glen Burnie, MD 21061

18. Mother's Name (First, Middle, Maiden Sumame)

Immediate Cause (Final disease or condition resulting in death) Due to (or as Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

21. Signati

23b. Was decedent pregnant in the past 12 months? ☐Yes 2☐No 9 Unknown

23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 4□Pregnant at time of death 9 Unknown

Due to (or as a consequence of):

3 Ectopic pregnancy 5 Other (specify)

23d Date of delivery Month Day

20c. Location - City or Town, State

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 □Unknown

24a. Was an 1 Yes 26. Place of Death (Check only one)

1 🗌 Yes

2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

Year

10d. Inside City Limits

1 ☐ Yes 2XXNo

25. Was case referred to medical examiner? Hospital: 2 No 1 Tyes 27. Manner of Death 1 Natural 5 Pending investigation

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred

6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier (Check only one)

29b. Signature and title of certifier

2 Accident

4 | Homicide

3 ☐ Suicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of Burokn

Onsim 31. Date filed (Month, Day, Year

JUN 2 9 2004

Registrar DHMH 17 Rev 1/2001

nours after death.

nerel Director: After this filled in by the funeral d

within 24 hours a To the Funerei L

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No: 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 8:25 PM DOWEL 200 06 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE, MD BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 7,F 217-38-4169 62. Yrs. Director Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTIMORE BALTIMORE 1 ☐ Yes 2 No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Was Decedent Ev Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 1 No Specify: ģ 3 ☐ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic avant, Ite Ma College (1-4or 5+) Elementary/Secondary (0-12) ecretari 12 18. Mother's Name (First, Middle, Maiden Sumame, 17. Father's Name (First, Middle, Last) Howard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTIMORE, MD 21222 20a. Method of Disposition
1 □ Burial 2 Di Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Date 20b. Place of Disposition (Name of 20c. Location - City or Town, State competery, crematory or other place)

4NS FUNERAL CHAPER - 6/29/04 FOREST HILL EVANS 21. Signature of Funeral Service Licen 22. Name and Address of Facility TIMONIUM, MD 2109 REACE FUL ALTGENATIVES FUNERAL & CREMATION CTR Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter the Griphy Cause (Disease or injury that initiated events resulting in death) Last Examine HYPOTENS Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 15, CORONARY ARTERY 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 ☐ Yes 2 📉 No 1 Inpatient 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Watural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide

Box 68760 Records, P.O. Division of Vital the Hospital or Attanding Physician:

the attending physician and thed for use as the burial-transit

"natural', or Itams 23a or 28a-f show

Baltimore, Maryland 21215-0036

traumatic avant, the Madical Examiner must be notified at

within 24 hours after death. To tha Funaral Diractor: A

After this funeral

CHAZALEH ARAM

29a. Certifier

(Check only one)

29b. Signature and title of certified

Medical

31. Date filed (Month, Day, Year) JUN 2 9 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 EASTERN AVE BALTIMORE MD ZIZZY

32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 40

6/26

Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death edent's Name (First, Middle, Last) Month **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONEYSUCKLO 36 Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Months Days Hours Min. Country 134-88-4056 1 M 2 KF Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28s-f show is marked other then "naturel", or Iteme 23s or 28s-f shor reumstic event, the Medical Examiner must be codified at 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1636 210 56 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Btack, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: Mut þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation e kind of work done do DO NOT use retired) during most of working Etementary/Secondary (0-12) College (1-4or 5+) 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be f Department of Health and Mental P Important: If Item 27 is marked of ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 19a. Informant's Name/Relationship (Type, Print) State, Zip Code) 20b. Ptace of Disposition (Name of cemetery, crematory or other place Date 20a. Method of Disposition Sune 28 20c. Location - City or Town, State 1 8urial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee UKUROD 22. Name and Address of Facility EVANS Chapel any ir NUMBER OF Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METASTATIC **Physician** MALICINANT MELANOMA YEARS disease or condition resutting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any leading to mineral cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner the attending physician and the for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 200 1 TYes 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed 1 Yes 2 X No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation 1) Naturat 1 ☐ Yes 2 ☐ No hours after death. 2 ☐ Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) sallam M.D 06-25-2001 D45530 30 Name and address of person who completed cause of death (ttem 23a) (Type, Print) 8114 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State Registrar

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Ma			artmen rtificate			and M		giene Nog. No. (	nl	201:18
	Physici	an	1. Decedent's Name (First, Middle, Last	)							2. Date of Dea Month	ith Day	Year	3. Time of Death
	/Media	cal	Bernetta Ernst				45 000	Tana	1 annting	(2	June	25	2004	3:15A M
4	Examir	ier	4a. Facility Name (If not institution, give 1516 Miller Road	street and number)					Location of	or Death			unty of Deat	h
	Funeral		Social Security Number 6. Se		e (In yrs. last birth	day)	West:	1 Year	If Under		8. Date of Birth	1	7011 9. Birt	hplace (State or Foreign
	Director		212-01-3207	]M 2017	84 Y	rs.	Months	Days	Hours	MH1.	May 31,	1920	Ma	ryland
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Lo	cation							10d. Inside City Limits
	Mary f sho	tor	Maryland Carro	11	West	mi	inster	-						1 ☐ Yes 2 ☑ No
	h the	Director	10e. Street and Number				10f. Zip					10g. Citizer	of What Co	untry?
	23a c		1516 Miller Roa	ad				21	158			U.	S.A.	
	tems er in	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		13. \ I	Was Deced If Yes, spec	ent of His	spanic Orig	gin? (Spe , Puerto l	cify Yes or No- Rican, etc.)	14.	Race - Ame Black, White	
36	ous after death with the Marylar ral', or Items 23a or 28e-f show Exsoliter tower by retilling at	by F	1 Never Married 2 Married 3 X Widowed 4 Divorced	1 Yes 2 1 If Yes, Give Year or Dates:	No		1 ☐ Yes 2	≥ <b>⊠</b> No	Specify:			Sp	ecify: Whi	te
9	tiled within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28e-f show with the Medical Executes must be rediffed at	ted	15. Decedent's Edu	cation	16a. [	Эесес	dent's Usua	I Occupa	tion				of Business/	
215	thin 7 e.	Completed	(Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4or 5	5+)	Give life. l	kind of wor DO NOT us	k done d e retired)	uring most	t of workir				
21	ygien ygien her th	Con	12		Se	ecr	etary							rity Admin
Maryland 21215-0036	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Mannatic event.	Be	17. Father's Name (First, Middle, Last)								(First, Middle,	Maiden Sui	mame)	
Ž	should Ind Meni	2	Lawrence H. Feehel		19b. /	Mailir	na Address	(Street a	Ethe.		i Route Numbe	r. City or To	wn. State. Z	in Code)
	2 5 5 G		Charles Ernst (So				=				inster,			
ore,	of Head		20a. Method of Disposition 1 ፟ Burial 2 ☐ Cremation 3 ☐ I	Dames and Assem Chata	20b. Place of E	Dispo	sition (Nam	ne of ther place	9)	D	ate	20c. Locati	ion - City or	Town, State
<u>Ĕ</u>	Pages ment of h ant: If ite ury or of		`4 □Donation 5 □Other (Specify,		Glen 1								Burnie	
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other <u>90ca</u> .		21. Signature of Europa Service Incens		1290	Wi 16	tzke 30 Ed	Fune Imond	s of Facility ral lson	Home Avenu	of Cato	onsvi nsvil	lle, I le, MD	nc. 21228
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of	ne cause on each li	ne.		er the mode	of dying	, such as	١.				Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	y stag	_	Re	w.	1	d	iseas	e		Criser and Dealir
	Examiner			- 1.	a consequence of	): ~~	~1 05	3 -						
		Jer	Sequentially list conditions,		a por sequence of	ji.								
	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	o										
50,	be executed sician and burial-transit	I Ex	resulting in death) Last	Due to (or as	a consequence of	):								
8760,	physic	dical		d										
9 xo	death certificate be executed e attending physician and nd for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome								23d	Date of deli	VARV
<u>.</u>	death	Icla	in the past 12 months? 1 □ Yes 2 □ No	4 Pregnant at	2 Fetal death time of death		Ectopic pre Other <i>(spe</i>						Month	Day Year
P.0	at the d by the stached	hys	9 Unknown	9 Unknown							1			
Ś	The law requires that the te has been signed by thoage 2 should be detache	by	Breat II. Other significant conditions co		ut not resulting in t	he ur	nderlying ca	iuse give	n in Part I.		23e. Did tol	V		the cause of death?
Vital Record	e law r has be je 2 sh	Completed									24a. Was a autops	y	prior to c	opsy findings available ompletion of cause of
E H		Con									perform 1 Yes	ned? No	death?	2 No
Vit.	Physician: Th this certificate ral director, paç	o Be	25. Was case referred to medical examiner?	fospital:				Othe	c		Check onl on			
of		$\vdash$	1 Yes 2 No 27. Manner of Death	28a. Date of Injur	ry 28b. Tin	ne of		Bc. Injury	at Nur	rsing Hom 2	ne SK Reside 8d. Describe ho		Other (Spec	ify)
ion	Attending ir death. ector; After by the fune	atloi	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	y Yea <i>r)</i> Inji	ıry	М	Work'	? es 2□N	No				
Division	after death after death Director; /	ertification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju-	ury - At home, fam	n, stre	et, factory,	office		2	8f. Location (St City or Town	reet and Nu	umber or Rui	ral Route Number,
	oital or ors afte rel Dire	O								14				
	To the Hospital of within 24 hours at To the Funerel D completely filled it	Medical	one)	sician: To the best oner: On the basis of and manner sta	examination and/	death or inv	estigation,	in my opi	inion, deat	d place, a h occurre	d at the time, d	ate and pla	ce, and due	to the cause(s)
)	To wit	-	29b. Signature and title of certifier	Anger 1	un		290.	License 5	170	5	2	ed. Date sig	ned (Month)	O P
	10		30. Name and address of person who come PANSURYA		Moore		DR.		str	in	ster,	mo	28-	57
	Sta Registr	•	31. Date filed (Month, Day, Year) JUN 2 9 2004	32. Registra	ar's Sign Jure	40	rocks	/						

			For State	State of M	aryland / Dep	artment of H			giene Reg. No/) ()	Ma. I
1. O. S. S. S. S. S. S. S. S. S. S. S. S. S.	v h		Registrar  1. Decedent's Name (First, Middle,	, Last)		Timouto of L	Journ	2. Date of De	ath C.U	a. Time of Depath
	Physici		1/0/11/	Man Sa	Hom			Month	Day 7	Year 4:30 PM
	/Medic Examin	1	4a. Fecility Name (If not institution,	give street and number)	25,001	4b. City, Town, or	Location of [	Death	4c. County	
	Examili	-	diadu mario	Adventor	+ Hozmital	Rockv	ille		Montg	
(gg.	Funeral		5. Social Security Number	6. Sex 7. Ag	ge (In yrs. last birthday	If Under 1 Year	If Under 24	Hrs. 8. Date of Bird Min. (Month, Da	h	Birthplace (State or Foreign Country)
5	Director		408-32-5563	1 □ M 2 🖾 F	82 Yrs.	Months Days	nouis	Aug 14	,1921	Virginia
	pu ,		Usual Residence of Decedent		10c. City, Town or L	coation				10d. Inside City Limits
	anyla shov	-	10a. State 10b. County							1 ☐ Yes 2½ No
	Me M	ecto	Maryland Mont	gomery	Gail	hersburg			10g. Citizen of W	
	with t	Funeral Directo		77 T)1		1				
	s 23	erai	9463 Hickory	12. Was Decedent	Ever in U.S. 13	20886		1? (Specify Yes or No	U.S	A.  - American Indian,
	ter d	Ë	1 Never Married 2 Marri	Armed Forces? ed 1 ☐ Yes 2 🛱	No No			n? (Specify Yes or No Puerto Rican, etc.)	Black	k, White, etc.
936	urs al	þ	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☒ No	Specify:		Specify	White
21215-0036	72 hours after death with the Maryland "natural", or Items 23a or 28e-1 show dical Examiner must be notified at	ted	15. Decedent' (Specify only highes	's Education	16a. Dece	edent's Usual Occupa kind of work done of	ation	f working	16b. Kind of Bu	siness/Industry
215	within 7 ene. than "r	ple	Elementary/Secondary (0-12)	College (1-4or	5+) life.	DO NOT use retired	)	, working		Grove State
	filed with Hygiene. Ither ther	Completed	12		Ca	shier			Hospi	
	₩ E P	Be	17. Father's Name (First, Middle, L					s Name (First, Middle,		θ)
<u>y</u> la		ဥ	Mercer Melvin					Robinette		
Maryland	s 1 and 2 should Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationsh					or Rural Route Numbe		
	f Healt item 2	1 0	Janie Koenig  20a. Method of Disposition	(Daughter)		Hickory osition (Name of omatory or other place		'i Gaithei Date		MD 20886 City or Town, Stete
آور	0 = 5		1 ⊠ Burial 2 ☐ Cremation				l l	6-20-2004		
Baltimore,	permit. Peg Department Important: any njury o		'4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Formal Service L							t City, Marylan
Ba	permit. Departm Imports any nju		V M	3 01	01290 1	litzke Fun 630 Edmon	eral H	lome of Cat	onsville	e, Inc. , MD 21228
			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that cause						Approximate Interval Between
	Dhusisian		Immediate Cause (Final		unonta					Onset and Death
4	Physician /Medical		disease or condition resulting in death)	- a	a consequence of):					s days.
V.	Examiner.			- Chron	we obst	motive &	rulmo	may brose	nie	2 years.
1		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of):			0		0
	cuted	Examiner	Cause (Disease or injury that initiated events	с						
0,	be executed sician and burial-transit	EX	resulting in death) Last	Due to (or as	a consequence of):					
8760,	0 2 0	dicai		d						
x 68	ding p	/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy				004 Day	
Вох	leath certificat attending phy I for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)			Mor	e of delivery hth Day Year
o.	that the de ned by the a detached f	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown						
Δ.	es that igned by be deta	by Ph	Part II. Other significant condition	ns contributing to death I	but not resulting in the	underlying cause give	en in Part I.	23a. Did to	obacco use contri	ibute to the cause of death?
rds	n signe	q p						יםו 🕴 יםי	′es 2 🗆 No	3. Probably 4 □Unknown
Records,	s been s	jete						24a. Was	an 24b. W	Vere autopsy findings available rior to completion of cause of
Re	The law requires that the cate has been signed by the page 2 should be detache	Completed							rmed?_   d	eath?
Vital		BeC	25. Was case referred to medical				26. Place of	f Death (Check only o		
<b>†</b> \	S S	To	examiner? 1 ☐ Yes 2 ☑ No	Hospital: Inpati			4 U Nursi	ing Home 5 ☐ Resid	ience 6 □Othe	or (Specify)
n of	ding Ph h. After th funeral	:uo	27. Manner of Death  Natural 5 ☐ Pending	28a. Date of Inj (Month, Da	ury 28b. Time (	of 28c. Injun Work	y at k?	28d. Describe h	ow injury occurre	ed .
Sio	Attending r death. ector: After by the fune	cati	2 Accident investig	pation			Yes 2 □ No			
Division	I or Attendi atter death. Director: A I in by the fu	Certification:	4 Homicide determi	ZOB. PIACE OF IT	ijury - At home, farm, s tc. (Specify)	treet, factory, office		28f. Location (S City or Tov		er or Rural Route Number,
	pitel ours a erel [		29a. Certifier 1 Certifyin	g Physician: To the best	of my knowledge, dea	th occurred at the tim	ne date and	place, and due to the	cause(s) and mar	oner as stated
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Medical	(Check only 2 Medical I	Examiner: On the basis of and manner s	of examination and/or i	nvestigation, in my of	pinion, death	occurred at the time,	date and place, a	nd due to the cause(s)
	ro thi Mithin Fo th	₩	29b. Signature and title of certifier			29c. License	e number		29d. Date signed	(Month, Day, Year)
			) WH			61	576		6/25/0	4 June 20 70011
	8.4		30. Name and address of person	who completed cause of	death (Item 23a) (Type	, Print)		1 1		
_	X		lei yu	M.D. 89	10 Medre	al Orive	gai	thersburg	mo	20810
	Sta		31. Date filed (Month, Day, Year)		trar's Signature	/	U	(		
	Regist	rar	JUN 2 9 20	04 Sever	a B	Sportal				

DHMH 17 Rev 1/2001

		4	State of Maryland / Department of Health and M State Registrar AMEND ITEM 20B PERFH, G833, 07/02/04/04/04/05	ental Hygier	ne	
			Registrar  1. Decedent's Name (First, Middle, Last)	Reg. I	46. 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	201 20
	Physicia		CLT FFORD FERGUSON		26 200	4 1904 M
	/Medic	al -	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of Dear	11101
	Examin	er		ore	N/A	7
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Yea	9. Bin	thplace (State or Foreign
	Director		251-56-6200 194 20F 72 Yrs. Months Days Hours Min.	NOV 41	931 Sou	the anolon
	D		Usual Residence of Decedent  10a, State 10b, County 10c, City, Town or Location			10d. Inside City Limits
	shov shov	5	led N/A Ba/timore			1 ☐ Yes 2 ☐ No
	the N	Director	10e. Street and Number 1 10f. Zip Code	10g.	Citizen of What Co	puntry?
	with la or		26.9 W Hallins St. 21223		115.4	1.
	ns 23	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe	cify Yes or No-	14. Race - Ame	
۵	or ital	Ξ	Armed Forces?  1 Never Married 2 Married 1 Yes, Specify Cuban, Mexican, Puerto 1 Yes, Sive 1 Yes, Specify Cuban, Mexican, Puerto 1 Yes, Sive 1 Yes, Specify:	Hican, etc.)	Black, Whit	
5-0036	within 72 hours after death with the Maryland ene. Than "natural", or Itams 23s or 28s-f show to Medical Examiner must be notified at	d by	3 Widowed 4 Divorced Year or Dates:		Specify:73	
ה	within 72 hours ene. than "natural", the Medical Era	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of work)	ng 16b.	. Kind of Business	/Industry
2	within jiene. r than	du	Elementary/Secondary (0-12) College (1-4or 5+)		on stru	ction
N	be filed with tal Hygiene d othar thai evant, Ital			(First, Middle, Maio	len Sumame)	
au	eve eve	To Be	Tours Faranson Elwilli	Book	er	
Maryland	nd N	F	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Ryra	I Route Number, Cit	y or Town, State, .	Zip Code)
	d 2 h a 7 is		Emma Tarqueon Wite 2614 Lauretta An	e. Balto	. Ild.	21223
altimore,			20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	704 200	Location - City or	Town, State
Ĕ			'4 Donation 5 Other (Specify)	1,2004 D	allo. U	d.
Balt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee  (22. Narme and Address of Facility Carl For Cull of Surface)	7. Balk	ral Seri	1217
Г			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line.	or respiratory arrest,		Approximate Interval Between
,	Physician .		Immediate Cause (Final disease or condition 3-205)			Onset and Death
	/Medical		resulting in death)  Due to (or as a consequence of):			1 00000
	Examiner		Sequentially list conditions, b. fulm, nant nepatitis			4 days
	p sit	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury			O
	xecute and i-tran	хап	resulting in death) Last  Due to (or as a consequence of):			
8760	ate be executed physician and the burial-transit					
687	ficate p physics the	edicai	Q			
Вох	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy		23d. Date of de	
œ.	death	sicia	in the past 12 months?  1 Yes 2 No  4 Pregnant at time of death 5 Other (specify)		Month	Day Year
Р. О.	res that the de igned by the a be detached f	hys	9 Unknown	00. 10:11.1		
	es th igned be de	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	1 ☐ Yes		o the cause of death?
ord	w require been signature	ted		-		
Division of Vital Records,	e law i has b	Completed		24a. Was an autopsy performed	prior to	utopsy findings available completion of cause of
E .		Co		1 Yes 2		2 □ No
V Its	ician: Th certificate rector, pag	Be	examiner? Other	(Check only one)		
ō	Phys rthis ral di	.: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	me 5 Residence 28d. Describe how in		icity)
OU	ding th. After fune	tion	1 XNatural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No			
/isi	Attendir death.	ifica	3 Suicide 6 Could not be	28f. Location (Street		ural Route Number,
á	al or A s after i Dira	Certification:	4 ☐ Homicide building, etc. (Specify)	City or Town, St	a10)	
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: Atter this certifics completely filled in by the funeral director.	Medical (	29a. Certifier (Check only one)  1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner stated.			
	To the within 2 To the complet	Me	29b. Signature and title of certifier 29c. License number	29d.	Date signed (Mon	th, Day, Year)
	, , , ,		Any Shootad MA 15893	15	whe 2	6,2004
	b		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	2		
			Amy Rogstad, MD 22 South Greene St.	Korm N3	t10 ba	8+ WD 51501
	Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature			

		For State Registrar		of Marylar	nd / Depa		nt of H	ealth ar	nd Me	ntal Hyg	leg. No. 2	004	2042
Physicia /Medic Examin	ai	Decedent's Name (First, Middle,     DOHN A.      Facility Name (If not institution,     Brightwood Cent	OERT	SCH B	ECK	4b. City	Town, or Luthe	Location of	Death	. Date of Dea Month Diい と	Day 28 4c. Coun Ba		re Co.
Funeral Director		215-22-9855	Sex 12ÖSM 2☐F	7. Age (In yrs. 76	last birthday) Yrs.	If Unde Months	r 1 Year_ Days	If Under 24 Hours	Min.	Date of Birtl (Month, Day OCT.	Year 27	9. Birth Cou Mar	place (State or Fore ntry) 'Yland
deeth with the Maryland me 23a or 28a-f show rmust be notified at	ctor	Usual Residence of Decedent           10a. State         10b. County           Maryland	Baltimo		ty, Town or Lo	ocation	Timo	nium					10d. Inside City Lim 1 ☐ Yes 2 🛭
with the	ai Dire	10e. Street and Number 3 Elphin Court	Unit	201		10f. Zi	Code	2109	93		10g. Citizen o Unite	of What Cou ed Sta	
5 <b>2</b> 2	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	Armed	cedent Ever in U Forces? : 2 No Give Dates:		Was Dece If Yes, spe 1  Yes		spanic Origin , Mexican, i Specify:	n? (Specit Puerto Ric	fy Yes or No- can, etc.)	14. R	ace - Ameri lack, White, cify:	
1215-UU36 Within 72 hours efter ene. then "neturel", or ite	Completed by	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	grade completed	d) (1-4or 5+)	life.	kind of wo	ork done a	uring most o	of working		16b. Kind of		ndustry
and Z a be filled of other event, I	Be	12 Years 17. Father's Name (First, Middle, L John Foertscht			Sa	les_		18. Mother's			Ret Maiden Suma	cail ame)	
	ဥ	19a Informant's Name/Relationshi Mrs. Eleanora	(Type, Print)	Wife hbeck		ng Addres phin			or Rural F	Route Numbe	r, City or Tow	Maryla	and 2109
Pege Pege nent c		20a. Method of Disposition 1 ☐ Burial 2X☐ Cremation 1 ☐ Donation 5 ☐ Other (Special Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control	icity)	n State	Place of Dispo cemetery, cred 11top	serv.	ice C	orp.	Dat 5/29/		20c. Location		own, State aryland
Battime permit. Peg Depertment Important: eny Injury 6		21. Signature of Furieral Service Co.  23a. Part1. Enter the disease, or one shock, or heart failure. List of	18.	-My		ouda-1	Ruck	Ave.	Dund	alk. M	Dundal arylan	lk, Ir	1C • 222 Approximate
th certificate be executed the certificate be executed the certificate and certificate and certificate as the buriel-trensit	ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	b. Due t	o (or as a consection or or as a consection or or as a consection or or as a consection or or or or or or or or or or or or or	quence of):			574	re .	CAR	(C) NO	DNA	MONTE
O. E. E. E. E. E. E. E. E. E. E. E. E. E.	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	1 Live	outcome of pregn birth 2 Feta gnant at time of o	al death 3[	⊒Ectopic p ⊒ Other (s						Date of deliving	<b>ery</b> Day Year
Cords, P.	ed by Ph	Part II. Other significant condition	s contributing to	death but not res	sulting in the u	inderlying	cause give	n in Part I.					he cause of death?
I Reco The lew re ate hes bee page 2 sho	Somplet									24a. Was a autop perfor	n 24b sy med? 2 No	death?	opsy findings availa impletion of cause of 2 No
of VItal Re Physician: The this certificate he	To Be	25. Was case referred to medical examiner? 1 Tyes 2 Dec			ER/Outpatie		OA Othe 28c. Injury Work	r: 4 Nurs	ing Home		ence 6 □O ow injury occ		fy)
or Attender der der der der der der der der der	Certification;	1-Maturat 5 Pending investige 3 Suicide 4 Homicide	tion of be 28e. Pla	te of Injury onth, Day Year) ce of Injury - At h Iding, etc. (Speci	Injury nome, farm, st	М	10,	? /es 2 □ No		f. Location (S City or Tow	treet and Nun n, State)	nber or Run	al Route Number,
e Hospital n 24 hours e ne Funerel I	Medical C		xaminer: On the	he best of my kno basis of examina anner stated.									
To the within 2 To the complet	Me	29b. Signature and title of certifier	5	Suple	Mo		DOO		50		29d. Date sign		
1/g		30. Name and address of person w	ALA (	GUPTA	) MD	Print)	Box	r 63	03	ELC	1607	7 (17	3 200 4 D 4 2 104
Sta Registr		31. Date filed (Month, Day, Year)	32	Registrar's Sign	ature	WEL.							

			State of Maryland / Department of Health and M - State of Maryland / Department of Health and M - State of Maryland / Department of Health and M - State of Maryland / Department of Health and M - State of Maryland / Department of Health and M - State of Maryland / Department of Health and M - State of Maryland / Department of Health and M - State of Maryland / Department of Health and M - State of Maryland / Department of Health and M - State of Maryland / Department of Health and M - State of Maryland / Department of Health and M - State of Maryland / Department of Health and M - State of Maryland / Department of Health and M - State of Maryland / Department of Health and M - State of Maryland / Department of Health and M - State of Maryland / Department of Health and M - State of Maryland / Department of Health and M - State of Maryland / Department of Health All M - State of Maryland / Department of Health All M - State of Maryland / Department of Health All M - State of Maryland / Department of Health All M - State of Maryland / Department of Health All M - State of Health All M - State of Health All M - State of Health All M - State of Health All M - State of Health All M - State of Health All M - State of Health All M - State of Health All M - State of Health All M - State of Health All M - State of Health All M - State of Health All M - State of Health All M - State of Health All M - State of Health All M - State of Health All M - State of Health All M - State of Health All M - State of Health All M - State of Health All M - State of Health All M - State of Health All M - State of Health All M - State of Health All M - State of Health All M - State of Health All M - State of Health All M - State of Health All M - State of Health All M - State of Health All M - State of Health All M - State of Health All M - State of Health All M - State of Health All M - State of Health All M - State of Health All M - State of Health All M - State of Health All M	lental Hy	giene Reg. No: ) () () ()	
•			Registrar  1. Decedent's Name (First, Middle, Last)	2. Date of De	ath CUUS	3. Time of Death
	Physicia		Isabelle V. Finnegan	Month June	19, 2004	12:43 A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of Dea	ath
			Gilchrist Towson  5. Serial South Number 5. Sex 7. And (In was last hirthday) If Under 1 Year If Under 24 Hrs.	8. Date of Bir	Baltin	
	Funeral Director		5. Social Security Number 6. Sex 1 $\square$ M 2 $\boxtimes$ F 7. Age (In yrs. last birthday) If Under 1 Year 1 Under 24 Hrs. Months Days Hours Min.	(Month, Da		nthplace (State or Foreign ountry) altimore
	D		Usual Residence of Decedent	вере.	JO, 1725 B.	
	arylan show	L	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 ☐ Yes 2 📉 No
	he Ma 28a-f	Director	MD Baltimore Owings Mills  10e. Street and Number 10f. Zip Code		10g. Citizen of What C	country?
	death with the Maryland me 23a or 28a-f show rmust be notified at		12214 Bonita Ave. 21117		USA	
	death ime 2:	Funeral	12 Was Decedent Ever in U.S. 13 Was Decedent of Hispanic Origin? (Sp.	ecify Yes or No Rican, etc.)	14. Race - Am Black, Wh	erican Indian, ite, etc.
g	or fite	y Fu	1 □ Never Married 2 1 ☑ Married 1 □ Yes 2 1 ☑ No If Yes Give 1 □ Yes 2 1 ☑ No Specify:			White
Š	tural,	ed by	3 Widowed 4 Divorced Year of Dates:  15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Business	s/Industry
7.	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	piet	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  (Give kind of work done during most of work life. DO NDT use retired)	ing		
21.0	ad with	Completed	12 N/A Homemaker		Own I	Home
5	tal Hy de file	Be			, Maiden Sumame)	
2	hould d Mer marks matic	ဥ	Harry G. Ellison  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Run	a Ca1v		Zip Code)
2	IVICA Did 2 s Ith an Ith an 27 Is I				11s, MD 21:	
Ş	S 1 ar		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City o	
Ē	Page Page Tient c ant: If ury or		'4 □Donation 5 □Other (Specify) Veterans Cemetery 2004	4 2 ,	Owings	Mills, MD
Monday Monday	pairilliore, Index yield A 12.13-0050 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deperment of Heelih and Mental Hygiene. Important: If Item 27 is marked other than "natural, or Iteme 53a or 28a-1 show any injury or other traumatic event, the Maryland Examiner must be notified at once.		21. Signature of Funeral Service bicensee  Michael J. Flagle  22. Name and Address of Facility Lemmon Funeral Home 10 W. Padonai koad	e of Du	laney Valle	ey, Inc.
			Michael J. Flagle 10 w. Padonal Road  23a. Part for the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac			Approximate
50	- November		shoot, or heart failure. List only one cause on each line.	lad	14. 2002.	Interval Between Onset and Death
0.1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. CPS/S S ndrome  Due to (or as a consequence of):	78 15	211 - CV 7 1117	weeks
0	Examiner		MULTI-ORGAN FATLURE			
+	D #5	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	)	1.7.	15,000
0	ate be executed thysician and the burial-transit	Examiner	that initiated events c.	DIOVASC	ular Diseaso	15 years
9	te be e. ysician	icai E	Due I (or as a consequence of):  d. Chronic anemia	8 My 21	io, My	342015
) 0	. DOX DO ( DO), death certificate be executed e attending physician and of for use as the burial-transit		The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s	Hiring		-
	DOX OS  Beath certific attending pi for use as I	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy	2'	23d. Date of de Month	elivery Day Year
ي رپو	ie dea the at hed fc	sici	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown  1 ☐ Yes 2 No 9 ☐ Unknown			,
-	The law requires that the de tale has been signed by the a page 2 should be detached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did t	obacco use contribute	to the cause of death?
abel	dS,	d by	Dseudomembranous colitis	10	Yes 2 No 3□F	Probably 4 Unknown
Z.	ecords law requires as been sign	Completed	congestive Henry failure	24a. Was	an 24b. Were a	autopsy findings available completion of cause of
1 , 1 0		Com	right Hip Fracture	perfo 1 ☐ Yes	ormed?   death?	s 2 No
17	VITAL I	Be	25. Was case referred to medical 26. Place of Deat			17
5 3	OT VITAL Physician: r this certifical ral director,	T.	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho 27, Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		dence 6 X Other (Sp	ecity) Hospice
2	ding th. After	tlon	/Month, Day Year) Injury Work?  1 Pending (Month, Day Year) Injury Work?  1 Yes 2 No	Sall w	hile WALKin	ng
2	IVISION or Attending ter death. Irector: Atte	Certification:	3 Suicide 6 Could not be determined 4 Homicide 2 le. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (	Street and Number or F wn, State)	Rural Route Number,
2 2	tal or	Cert	Private résidence	50107	Ten Mills K	d. Columbia, m
innegan	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral directors.	edical	29a. Certifier (Check only one)  Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, 2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	and due to the red at the time,	cause(s) and manner a date and place, and du	as stated. ue to the cause(s)
14	o the ithin 2 o the omplei	Med			29d. Date signed (Mor	nth, Day, Year)
	⊢≯⊢ŏ		M. Anthony Riley up D25d05		June 19,	2004
			29b. Signature and title of certifier  29c. License number  29c. License number  D25d05  30. Name and address of person who competed cause of depth (Item 23a) (Type, Print)  W. Anthony R. Ley GBMC 6701 N. Charles	C) /	2001. 11	1 21214
	5		W. Anthony Riley 68mc 6701 N. Charles	Sr. E	act. M	
	St Regist	ate rar	31. Date file WN 209 12004 \$2. Registrar's Signature			
	Tiegist	·u	- Freeze			

			for Stete Registrer	State of M	laryland		artment of F			, ,	iene	04	20423	
	Physici	an	Decedent's Name (First, Middle, Las	,					2	2. Date of Deat Month	h Day	Yeer	3. Time of Death	
1	/Medic Examin	al	Joyce Anita Fors 4e. Facility Name (If not institution, give		)		4b. City, Town, o	r Location o		une 2	T	004 y of Deeth	6:00a M	
	Examin.	ici	Charlestown Retir				Catons			_	Ва	altim	ore	
	Funeral		5. Social Security Number 6. Se 216–28–4996	0X 7. A0	ge (In yrs. Ia	st birthday) Yrs.	If Under 1 Year Months Days	If Under:	24 Hrs. 8 Min.	Date of Birth (Month, Dey, ugust 9	Year)	Cou	place (Stete or Foreign intry)	
	Director		Usual Residence of Decedent		72	113.			A	ugust 9	,1931	Mar	yland	
	nyland show	_	10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limits	
	he Ma 8a-f s	Directo	Maryland Balti	more		Cato	nsville			1.4	0		1 Yes 21 No	
	with t	DI	10e. Street and Number 1227 Pleasant Va	llev Driv	' P		10f. Zip Code	228		10	og. Citizen of U.S.		intry?	
	death	Funeral	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S	. 13.	Was Decedent of H		gin? (Speci	fy Yes or No-	14. Re	ce - Ameri	can Indian,	
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Itams 23a or 28a-1 show aumatic event, the Madical Examana multipe confiled at	by Fu	1 Never Married 2 Married	1 Tes 2 X			1 □ Yes 2 🖾 No	Specify:		carr, etc.)	Speci	ick, White		
Maryland 21215-0036	hours tural	ed b	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Ed	Year or Dates:		16a, Deced	dent's Usual Occup	ation			16b. Kind of E	wn	ite	
212	thin 72 Br. na Medit	Completed	(Specify only highest grade Elementary/Secondary (0-12)		5+)	(Give life. I	kind of work done DO NOT use retired	during most d)	t of working	'		, , , , , , , , , , , , , , , , , , , ,	iddairy	
2	ygiene ygiene nar tha	Соп	10th			Home	maker					Home		
and	B B B	Be	17. Father's Name (First, Middle, Last) Charles Godwin							First, Middle, M Philips		me)		
Ž	is 1 and 2 should of Health and Men tem 27 is marke other traumatic	ြ	19a. Informant's Name/Relationship (7	ype, Print)	7	19b. Mailin	ng Address (Street					State, Zi	p Code)	
	and 2 salth a n 27 is		George E. Forsyth	e (Husba	nd)		Pleasant							
Baltimore,	of He of He of He of them		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	000	ice of Dispo metery, cren	sition (Name of natory or other place	(e)	Dat	е 2	Oc. Location	- City or T	own, Stete	
Ħ	permit. Pages Department of I Important: If It any injury or o		`4 □Donation 5 □Other (Specify	)			Park Cem							
Ba	permit. Departr Importu		21. Signature of to rai Service cicen-		280	W3	Name and Addre	eral	Home	of Cato	nsvill	e, I	nc. ryland 21228	
	-21		23a. Pert1. Enter the disease, or comp	lications that cause	d the death							, Ma	Approximate Interval Between	
2	Physician		Immediate Cause (Final disease or condition  BLADDER CANCER  Onset and Death disease or condition											
	/Medical Examiner		resulting in death)	Due to (or as									- 1101111	
	*5.	er	Sequential / list conditions, if any, leading to immediate	b. — Due to (or as	a conseque	ence of).								
	uted d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	,										
Ö,	e exection and urial-tr	Exa	resulting in death) Last	Due to (or as	a conseque	ence of):								
8760	icate be executed physician and s the burial-transit	dlcal		d										
ox e	The law requires that the death certificate be executed to has been signed by the attending physician and te base 2 should be deliached for use as the burial-transit	Physician/Me	IF FEMALE:	23c. If yes, outcome	of pregnance	су		8: 69			23d D	ite of deliv	anı	
m.	death e atter d for u	iciar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	1□Live birth 4□Pregnant a	2 Fetal d	death 3□	Ectopic pregnancy Other <i>(specify)</i>	'				onth	Day Year	
0.0	that the de ed by the a detached	hys	9 Unknown	9LJ Unknown										
	ires tha signed I be det	þ	Part II. Other significant conditions co	ntributing to death t	out not result	ting in the ur	nderlying cause giv	en in Part I.		23e. Did tob			he cause of death?	
000	w require been si should t	eted							_	-				
Vital Records,	The lav	Completed								24a. Was an autopsy perform	ed?	prior to co death?	opsy findings available impletion of cause of	
<u> E</u>		BeC	25. Was case referred to medical					26. Place	of Death (0	1 ☐ Yes 2, Check only one		1 🗌 Yes	2 No	
	S D	ဥ	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Hospital: 1 ☐ Inpati			t 3 DOA Oth	4 🗆 Nui	rsing Home	5 Resider	nce 6 Oth	ner (Specil	ý)	
UC C	Jing P N. After funera	lon:	27. Manner of Death  1 Natural 5 Pending	28a. Date of Inju (Month, Da	ay Year) 2	28b. Time of Injury	Wor	yat k? Yes 2 □ N		d. Describe how	v injury occur	red		
Division of	or Attending Physician: after death. Director: Atter this certifici in by the funeral director.	Certification:	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of In	jury - At hom	ne, farm, str	eet, factory, office	163 2 1	281	Location (Str.	eet and Numi	per or Rura	al Route Number,	
á	s after al Dire	Cert	4 Homicide	building, et	tc. (Specify)					City or Town,	State)			
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	[Crieck Only 2   Medical Exerti	sicien: To the best iner: On the basis of	of my knowl	ledge, death	occurred at the tin	ne, date and pinion, deat	d place, and	d due to the car	use(s) and m	anner as s	tated.	
	ithin 2 o the	Med	29b. Signature applittle of certifier	and manner st	ated.		29c. Licens				d. Date signe			
	- 3 - 5		Ver Co	a MI	)				54		TIME	25	- 20011	
	15		30. Name and address of person who o	A -	death (Item 2	23a) (Type,	Print)	1	0.		٥٠٠٠	L. (2)	12009	
	1		Z-W. COCE S 31. Date filed (Month, Day, Year)	T AGNI	ES G	100	CATON	HVE	DAZ	TIMO	REN	10.	12004	
	Sta Registr		JUN 2 9 2004	A PARTIES	rar's Signar	TA	pour							

		1 - State Registrar			Ce	rtificate of	Death		Reg. No.	104	201.21.
Dhysioi	an.	1. Decedent's Name (First, Middle, La	ist)					2. Date of De	eath Day	Year	3. Time of Death
Physici /Medic		Carroll J. Flana	agan					June	24	2004	6:05P M
Examin	er	4a. Facility Name (If not institution, give					or Location of Death			unty of Death	
		Gilcrest Hospice 5. Social Security Number 6.5		e /in vrs la	ast birthday	Towson  If Under 1 Year	If Under 24 Hrs.	8. Date of Bir		timore	place (State or Foreign
Funeral Director			1 <b>3</b> ∑13M 2□F	82	Yrs.	Months Days	Hours Min.	Oct.17	,1921	Mary	ntry)
and *		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or L	ocation					I Od. Inside City Limits
hours after death with the Maryland turel; or Items 23a or 28e-f show Examiner must be notified at	ō	Maryland Baltin	nore		Cato	nsville					1 □ Yes 2X No
r 28e	Director	10e. Street and Number		1	0420	10f. Zip Code			10g. Citîzen	of What Cour	ntry?
h with		301 Wessling Cir	rcle			21	228		U	S.A.	
ems ?	Funeral	11, Marital Status	12. Was Decedent Armed Forces?	Ever in U.S	6. 13.	Was Decedent of I	Hispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No Rican, etc.)	o- 14.	Race - Americ Bfack, White,	
or It	by Fu	1 Never Married 2 Married	1 X Yes 2 □ I If Yes, Give	No		1 ☐ Yes 2 No		,		ecify:	
n 72 hours "neturel"	ed b	3 Widowed 4 Divorced	Year or Dates:	1	16a Dece	edent's Usual Occup	nation		16b Kind (	Wh i	
n "ne	piet	(Specify only highest gra Elementary/Secondary (0-12)	ade completed) College (1-4or 5	5.1	(Give	kind of work done DO NOT use retire	during most of worki d)	ing	l oo. mila	51 D0011103Q111	400117
d with giene er the	Completed	Elementary/Secondary (0°12)	2	,,,		Police C	aptain		Balt	imore (	City Polic
be file tal Hy d oth	Be (	17. Father's Name (First, Middle, Last	")				18. Mother's Name			name)	
ould Men varke	ပ	Robert Flanagan	T 011		400 14 11		Evelyn				0.11
12 sh h and 7 Is m treum		19a. Informant's Name/Relationship ( Joan Flanagan (V	Nife)				and Number or Rura		-		Code)
1 and Healt		20a. Method of Disposition	VIIC)	20b. Pl	ace of Disp	osition (Name of		Date		on - City or To	own, State
permit. Pages 1 and 2 should be liied within 72 hc Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "netur any injury or other treumatic event, it a Medical once.		1 Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Speci			•	matory`or other pla ark Cemet	· 1	-2004	Balti	more. 1	Maryland
mit. I partm porte inju		21. Signature of uperal service Lice	· · · · · · · · · · · · · · · · · · ·				ess of Facility Leral Home				
permi Depa Impo any in		PH	/ M	0/29	70 N	630 Edmon	dson Ave	Catonsv	ville,	MD 212	228
	00000	23a. Part1. Enter the disease, or com shock, or her failure. List only	plications that caused one cause on each li	the death	. Do not er	ter the mode of dyi	ng, such as cardiac o	or respiratory a	rrest,		Approximate Interval Between
Physician		Immediate Cause (Finaf disease or condition resulting in death)	a. 15ch	em	10	Card	consop	atra			Onset and Death
/Medical Examiner		resulting in death)	Due to (or as	a consequ	ence of):		, ,	1			
t	-	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as	a consequ	ence of):						
xecuted and Il-transit	xaminer	if any, leading to immediate Cause (Disease or injury that initiated events	2							51	
9 ⊆.©	Еха	resulting in death) Last	Due to (or as	a consequ	ence of):	_					
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ertifica ling pt e as t	Med	IF FEMALE:	20- 1						1		
eath certificate be eathending physician for use as the burie	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetaf	death 3	☐Ectopic pregnanc☐ Other (specify) _	у		23d.	Date of defive Month	ery Day Year
at the de by the	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown	t time or de	alli 5	_ Other (specify) _					
The law requires that the death certificate be the has been signed by the attending physicia page 2 should be detached for use as the bur	by Ph	Part II. Other significant conditions	contributing to death b	ut not resu	Iting in the	anderlying cause gr	ven in Part I.	23e. Did 1	tobacco use	contribute to th	ne cause of death?
w requires been sign should be		COPO STEO	kes					1 🗆	Yes 2□N	o 3 🗆 Prob	ably 4 🗸 nknown
aw red	ompieted							24a. Was			psy findings available mpletion of cause of
	Com					Þ		perfo	ormed?	death?	·
ysicien: The is certificate hadirector, page	Be (	25. Was case referred to medical examiner?					26. Place of Death	Check only	one)		
Physiclen: this certific	٩	1 ☐ Yes 2 No	Hospital: 1 Inpatie		R/Outpatie	nt 3L DOA	ner: 4 ☐ Nursing Hor		-	Cther (Specif	il respice
Jing F	ion:	27. Manner of Death 1 Structural 5 Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time o Injury	Wo	ryat rk? ]Yes 2 □ No	28d. Describe	now infury on	curred	
death death ctor: y the	ertification:	2 Accident investigation 3 Suicide 6 Could not be determined	e Geo Blace of Ini	ury - At hor	me, farm, si	reet, factory, office				um <i>ber</i> o <i>r Rur</i> a	I Route Number,
i ter	erti	4 Homicide	building, et	c. (Specily)	)			City or To	wn, State)		
din din	O	29a. Certifier 1 ★ Certifying P	hysician: To the best	of my knov	vledge, dea	th occurred at the ti	me, date and place,	and due to the	cause(s) and	manner as s	tated.
ospitel o hours af unerel D	jai	(Check only of Mantings Com	miner: On the basis	d awami		COMPUTATION IN 1939 (		ent at the time	Date and pla		
the Hospitel of the Funeral Date of the Funeral Date of the Funeral Date of the funeral Date of the funeral Date of the funeral Date of the funeral Date of the funeral Date of the funeral Date of the funeral Date of the funeral Date of the funeral Date of the funeral Date of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the functi	<b>ledical</b>	(Check only 2 Medical Exa	miner: On the basis o and manner st	f examinati ated.	ion and/or ii						
To the Hospital or Attending Ph within 24 hours after death. To the Funarel Director: After th completely filled in by the funeral	Medicai	(Check only 2 Medical Exa	miner: On the basis o	f examinati ated.	ion and/or ii	29c. Licens			29d. Date si	gned (Month,	Day, Year)
To the Hospital or within 24 hours at To the Funeral D completely filled in	Medical	(Check only 2 Medical Exa	miner: On the basis of and manner st	ated.		29c. Licens			29d. Date si		Day, Year)

DHMH 17 Rev 1/2001

JUN 2 9 2004

State Registrar 32. Registrar's Signature

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

				State of Ma		ertificate of	neaith and Me Death	eniai myg	giene		
			Decedent's Name (First, Middle, Last	<u> </u>		Timouto or		2. Date of Dee		)-4-	3. Time of Peath
П	Physicia		Paul Bruce Flyn	ın			_	JUWE	23 VC	Year	23:20
The same	/Medica Examine		4e Fecility Name (If not institution, give				4b. City, Town, or Loc	ation of Deeth	4c. County	of Death	
1			University Hospit			Williada di Vana	Baltimor	e	N/A		
b	Funeral Director		212-46-5011	x 7. Ag	e (In yrs. last birthda) 71 Yrs.	Months Days	Hours Min.	B. Date of Birth (Month, Dey 08/20/	, Year)	9. Birthp Coun MD	
	pue M	-	Usuel Residence of Decedent  10a. State 10b. County		10c. City, Town or L	.ocation				10	0d. Inside City Limits
	Maryl -f ehc	ğ	MD N/A		R	altimore					1 XYes 2 □ No
	r 28s	Director	10e. Street end Number			10f. Zip Code			10g. Citizen of V	Vhat Coun	try?
	23a o		1190 W. Northern	Parkway		212				JSA	
	r dea	Funeral	11. Maritel Status	12. Wes Decedent   Armed Forces?		Was Decedent of I If Yes, specify Cub	Hispenic Origin? (Spec an, Mexican, Puerto R	cify Yes or No- lican, etc.)	14. Race Blac	e - Americ k, White,	
20	n 72 hours efter death with the Maryland "naturel", or frems 23s or 28s-f show edical Exardiner count be notified at	by Fi	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ 1 If Yes, Give Year or Detes:	No	1□ Yes 20XNo	Specify:		Specify	:	III
Maryland 21215-0020	2 hour	8	15. Decedent's Edu	ucation	16e. Dec	edent's Usual Occu	pation		16b. Kind of Bu	siness/Inc	White
215	c	Completed	(Specify only highest great Elementery/Secondary (0-12)	le completed) College (1-4or 5	life	e kind of work done DO NOT use retire	during most of working ad)	9	Private	e and	Public
21	d withir giene. er then	ē	12	5+		School Te	T			1001s	
pu	uld be filed fental Hygi rked other fic event, I	Be	17. Father's Neme (First, Middle, Last)				18. Mother's Name		Maiden Sumam	Θ)	
7	d 2 should be filed within the end Mental Hygiene. 7 is marked other than traumatic event, the M	၉	John Joseph Flynn  19a. Informant's Name/Relationship (T)		10h Mai	ling Address (Stree	Mary t and Number or Rural		r City or Town	State Zin	Code)
Ma	d 2 st th end 17 is n traur	- 1	Roger Davis/Broth			6 Ebbwood			ity, MD		
	s 1 end of Health item 27 other to	1	20a. Method of Disposition	iei-III-Lav	20b. Place of Dist	osition (Name of ematory or other pla		Date	20c. Location -		
E O	Page ento nt: if y or		1 ⊠ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify,		•	Park Ceme		/28/04	Baltimo	re.	MO
Baltimore,	in the parties of	1	21. Signature of Funeral Service Licens	iee	Loudon	22. Name and Addre	ess of Facility Ashton Schw	ah Fun	aral Hon	nο T	nc
m	Ped Oep in a property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the p	1	Mark XI	Luke	7	36 Edmond	lson Ave.	Baltime	ore, MD	2122	8
			23a. Pert1. Enter the diseese, or comp shock, or heart failure. List only of	lications that caused ne ceuse on each li	the death. Do not e	nter the mode of dy	ing, such as cardiac or	respiratory ar	rest,	1	Approximate Interval Between
And the second	Physician	- 1								1	Onset and Death
ſ.	/Medical		Immediate Cause (Final disease or condition resulting in death)	θ	septic					1	a HARS
		. e	,	0.0	Due to (or as a cons	equence of):				į	11
A	uted	Examiner	Sequentially list conditions	b. —	Due to (or es a cons	equence of):				- 1	
oʻ			Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury			,				i	
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Вох	The law requires that the death certif ate has been signed by the attending page 2 should be datached for usa a	Completed by Physician/M					turn in Bod I	nah Dida	abanaa uga aas	eribute te	the cause of death?
P.O.	the d	hys	Part II. Other eignificent conditions co			underlying cause g	ven in Part I.	100	os 2 No		oably 4 Unknown
<u>ر</u> ت	s that med to e date	٦	Atheres donote	Heart	13euse						
of Vital Records,	quire en sig ould b	8	Dicheter mellitu	2				24a. Was a	an autopsy med?	ava	ere eutopsy findings ailable prior to
eco	aw re as be 2 sho		guillain Bari						,	of o	mpletion of cause death?
E .	an: The law rtificate has b stor, page 2 s	5	garrier, sarri	re agrici				1□ Y	es 2 No	10	Yes 202/No
/ita	ilan: artific ctor	a	25. Was cese referred to medical examiner?	Hospital:			26. Place of Death				
of	Phys this aldi	<u>은</u>	1 ☐ Yes 2 ☑ No 27. Manner of Deeth	1 Livinpatie		ent 3L DOA	4   Nursing Horn		ence 6 LOthe		y)
on	ding Ph th. After th funeral	티	1 ☑ Naturel 5 ☐ Pending investigation	28a. Date of Inju (Month, Da	y Year) Injury		ork? ]Yes 2□No				
Division	Attending or death.  ector: After by the fune	Flea	3 ☐ Suicide 6 ☐ Could not be determined	200. Flace of Inj	ury - At home, farm, s c. (Specify)	treet, factory, office	2	8f. Location (S City or Tow		er or Rura	l Route Number,
ă	s afte	Certification:	4   Notificial	Duilding, et	c. (Specify)			,			
	To the Hospital or Attending I within 24 hours after death.  To the Funerel Director: After completaly filled in by the funer	Cal	(Check only 2 Medical Exam	iner: On the basis of	f exemination end/or	eth occurred et the t investigation, in my	ime, date and place, a opinion, death occurre	nd due to the o d at the time, o	cause(s) and ma date and place, a	inner as st and due to	tated. the cause(s)
	To the b within 2 To the C complet	Medical	one) 29b. Signature and title of certifier	and manner sta	ated.	29c. Licen	se number		29d. Date signed	d (Month,	Day, Year)
	5.₹±		-			r	36494		6/25	104	
		-	30. Neme end address of person who c	ompleted cause of c	leath (Item 23e) (Type	e, Print)					f., a. 1 2 3 -
	4		& DESALAM Unir	onsity sp	eallity his	spitel 60	1 South ch	aries s	r Ball	nmore	mnx1x30
	Sta	e	31. Date filed (Month, Day, Year)	32. Registr	er's Signature						
	Registra	ar	JUN 2 9 2004	Genelia	B 1	books					

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 8:22 P.M 26. 2004 June GLORTA MARTE FRAZIER /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Manor Care Towson Towson 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Min. Days Hours 1 ☐ M 2 💢 F 69 Director 214-34-1374 Aug. 6, 1934 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10h Count 10a. State r than "natural", or itams 23a or 28a-f show the Medicul Exarciner must be notified at 1 ☐ Yes 2 🕅 No Maryland Baltimore Baltimore Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 308 01d Trail 21212 U.S.A. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify. 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) at Hygiene. College (1-4or 5+) years Auditor Internal Revenue .. Pages 1 and 2 should be filed vitnent of Health and Mental Hygis tant: If item 27 is marked other tigury or other traumatic avent, in 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Η. Frazier Barbara E. Chandler ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (friend) 300 Old Trail Baltimore, Maryland 21212 Betty E. Pierson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) rtment rtant: If njury or Rest Lawn Memorial Gardens 6-30-04 La Vale, Maryland permit.
Dep rtn
Imports
any njt 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Leers 6500 York Road Baltimore, Maryland 21212 benan 23a. Part1. Enter re disease, or complications that caus shock, or heart fail are. List only one cause on each Approximate Interval Between Onset and Death death. Do not enter de of fying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or a Examiner physician and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Physician/Medical as ding IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 Ectopic pregnancy atte in the past 12 months? Month Day Year jo 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performed? has e 2 page certificate 1□ Yes ZIN Attanding Physician: director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No P 1 🗆 Yes 2 ER/Outpatient 3□ DOA this After thi funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 12 Natural 5 Pending 1 Yes within 24 hours after deam.

To the Funaral Director: F investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed n 23a) (Type, Print) use of death (Ite 7600 Osle 31. Date filed (Month, Day, Year) ar's Signature State JUN 2 9 2004 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

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Records,

Division of Vital

			For State	State of Marylan	nd / Departi	ment of He	ealth and M		000	
	_		For State RegistrarAMEND TTEM #  1. Decedent's Name (First, Middle, Last)	10e,17&19a PF	OR INTERES	54168731	/(34/1JH	2. Date of Death	No.	3. Time of Death
	Physici /Medic		RICHALD		7 4	ZDN	31	Jone	27 Year 27 200	408=47 M
	Examin	er	4a. Facility Name (If not institution, give :			City, Town, or L	A1 /L		HALL	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday) If	Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	9. Bir	thplace (State or Foreign ountry)
	Director		216-92-0054	³⁹ 39	Yrs.	onths Days	Hours Mill.			ryland
	and		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	ty, Town or Location	on				10d. Inside City Limits
	Manyl f sho	jo	MD Harford		Joppa					1 ☐ Yes 2 No
	h the	irec	10e. Street and Number			Of. Zip Code		10g	. Citizen of What C	ountry?
	ath wil	Funeral Director	1604 Heim Street			21085			USA	
	ltems	nue	11. Marital Status 11∕2 Never Married 2 Married	12. Was Decedent Ever in U Armed Forces?	I.S. 13. Was	Decedent of Hisp s, specify Cuban,	panic Origin? (Sp , Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
920	urs af	þ	3 Widowed 4 Divorced	1 ☐ Yes 2√7 No If Yes, Give Year or Dates:	10	Yes 2⊠No	Specify:		Specify: W	hite
2	within 72 hours after death with the Maryland ene. than "netural", or Items 23a or 28a-f show the Modical Examinating the neillised at	Completed	15. Decedent's Edu (Specify only highest grade		(Give kind	s Usual Occupati	ion ring most of work	ing 16	b. Kind of Business	/Industry
121	within sne.	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)	Carpent	VOT use retired)			Construct	ion
д 2	Hygie other ent, t	Be Co	17. Father's Name (First, Middle, Last)		Carpent		18. Mother's Nam	e (First, Middle, Ma		.1011
/lan	Mental Merked o	To B	PARK L. Gardner,	Sr.			RuthAn	n Grogg		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Ita Mucical Examiner man be notified at any injury or other traumatic event, Ita Mucical Examiner man be notified at another.		19a. Informant's Name/Relationship (Ty					al Route Number, C	04004	Zip Code)
	1 and Health em 27		Paul L. Gardner, J	r. / Drotner	106 W1 Place of Disposition Commetery, cremate			SSEX, MD	21221 c. Location - City or	Town, State
Baltimore,	Pages ent of ht: If it ry or c		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 1 ☐ Donation 5 ☐ Other (Specify)	temoval from State				2004 B	eltsville	MD.
a E	partmi portar y injui		21. Signature of Funeral Service License		22. Na	ime and Address	of Facility	armann D	۸	, 1115
<u>~</u>	88 2 2 8		Holell	M00986	8717	Green I	Pastures	ormann, P. Dr., Tow	son, MD	21286
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.						Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	aDue to (or as a conseq		OCACO	MAL.	ENFAR	CHON	
	Examiner		Sequentially list conditions,	o. —————						
	ed sit	niner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	quence of):					
<u>,</u>	s be executed sicien and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a conseq	quence of):	<del></del>				
3760,	ate y at	icai		1						
9 xo	eath certifica attending pl	Physiclan/Med	IF FEMALE:	.3c. If yes, outcome of pregna	ancv				02d Data of da	line.
Bo	death of attent	clan	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Feta 4 Pregnant at time of d	al death 3 □Ect	opic pregnancy ner (specify)			23d. Date of de Month	Day Year
<u>о</u>	that the de led by the a detached f	hys	9 🗆 Unknown	9□ Unknown						
Ś	ires tha signed d be del	by	Part II. Other significant conditions con	tributing to death but not res	sulting in the under	lying cause given	in Part I.	23e. Did tobac	0.00	o the cause of death? robably 4 □Unknown
Record	w requir been si should	etec						24a. Was an		utopsy findings available
Re	The lav	Completed						autopsy performed	prior to death?	completion of cause of
Vital		Be C	25. Was case referred to medical				26. Place of Deat	h (Check only one)	2/40 1 1 1 6:	20.00
	hysic this ce al dire	ဥ	IDE TES ZUNO	-	ER/Outpatient		4   Nursing Ho	me 5 Residenc		ecify)
ono	ding Phy h. After the funeral o	tion:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury a Work? M 1 ☐ Ye	at es 2 □ No	28d. Describe how	injury occurred	
Division of	or Attendate death	ertification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street,			28f. Location (Stree City or Town, S	at and Number or R	ural Route Number,
Ō	iltal or A	O	4 Ditoliticide	building, etc. (Opecin				Ony or form, c		arana arang s
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this cartifics completely filled in by the funeral director,	edical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death ocation and/or investi	curred at the time gation, in my opir	, date and place, nion, death occur	and due to the caus red at the time, date	e(s) and manner as and place, and due	s stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	<b>&gt;</b>		29c. License r	number	29d.	Date signed (Mont	th, Day, Year)
}	*		19 much	Mhu	DMG	02	1809	1	0~Z7, 2	.004
	7		30. Name and address of person who co	ompleted cause of death (Item	- 1		> 1101	ONIUM.	MA 71	ान २
	, Sta	te	31. Date filed (Month, Day, Year) Q 20	32. Flegistrar's Signa			1	0.41014	10 41	
	Registr	ar	00H & 3 20	104	No popular	MOL .				

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gardner, Bichard 420267(4)

		-	For State Registrar	State of Ma	aryland /	-	rtment tificate			and Me		jiene		20428
	Dhysini	20	1. Decedent's Name (First, Middle, L	.ast)						1	2. Date of Dea Month	th Day	Year	3. Time of Death
	Physicia /Medic	al .	Edward Lawson								TUNE		2004	8:40A M
	Examin	er	4a. Facility Name (If not institution, g		, ,		4b. City, T			of Death		1	y of Death	2.2
			Morningside House 5. Social Security Number 6.		Ship e (in yrs. last b	irthday)	If Under 1	nove Year	er If Under:	24 Hrs.   8	3. Date of Birth		e Aru	
	Funeral Director		212-09-1453	tXDM 2□F	91	Yrs.	Months	Days	Hours		B. Date of Birth (Month, Day Mar. 1		Mary	lace (State or Foreign try) land
	D		Usual Residence of Decedent		r					1.5				
	arylan show d at	_	10a. State 10b. County		10c. City, Tov	wn or Lo	cation						1	0d. Inside City Limits 1,□ Yes 2 □ No
	Ba-f s	Director	Maryland		Bal	Ltimo		2 - 4-			Т.	10- 02:	11/h - 1 C	
	with ti		10e. Street and Number	7			10f. Zip (					10g. Citizen of		ii .
	eath	Funerai	610 Old Home Roa	12. Was Decedent	Ever in U.S.	13. V	Vas Decede		spanic Ori	gin? (Spec	ify Yes or No-	Unite	d Stai	
	r iten	Fun	1 ☐ Never Married 2 ☐ Married	Armed Forces?  1  Yes 2 If Yes, Give	No	"	Yes, specif	fy Cubar	ı, Mexicar	n, Puerto R	ican, etc.)		ack, White,	
ဗ္ဗ	ral', o	t by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:			∏ Yes 2	F1 NO	Specify:			Spec	w. Wh:	ite
5	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show than "natural" or items or or or of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the confidence of the conf	Completed	15. Decedent's (Specify only highest of	Education grade completed)	16	(Give	lent's Usual kind of work DO NOT use	done di	uring mos	t of working	7	16b. Kind of I	Business/Ind	dustry
2	within ane. than	ш	Elementary/Secondary (0-12)	College (1-4or	5+)		inet N	,				Carpe	ntry	
2	filed Hygid ther ant, II		17. Father's Name (First, Middle, La	st)		Cab	riiec i			er's Name (	First, Middle,	Maiden Suma	me)	
an	id be ental ked c	To Be	George Edward G	arner					Bess	sie Ma	arie La	wson		
Maryland 21215-0036	shou and M s mar		19a. Informant's Name/Relationship	(Type, Print)	19	b. Mailin	g Address (	Street a	nd Numbe			r, City or Town		
	and 2 salth a n 27 i	1	Joan Simms - Daug	ghter			Ashbur		Cour					and 21108
ore	of He of He if itan		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	☐Removal from State	20b. Place cemet	of Dispo: ery, cren	sition (Name natory or oth	e of her place		Da		20c. Location	- City or To	wn, State
Ē	Pag tment tent: jury c		' 4 ☐ Donation 5 ☐ Other (Spe	cify)	Holy					5/30/0				Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic evant, the Madical Examiner must be notified at once.		21. Signature of Funeral Service Lic			Ga 72	ary L. 250 Wa	Address Kai ashii	s of Facility ufmar ngtor	r Fune Blv	eral Ho 1. Elk	me At ridge,	MMP., Mary	Inc. land 21075
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	emplications that caused by one cause on each li	the death. Done.	not ente	er the mode	of dying	, such as	cardiac or	respiratory an	est,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	-a. END	STAC	SE	DE	ME	NTI	A				
	/Medical Examiner		resulting in doctri	Due to (or as	a consequence	e of):								
		er	Sequentially list conditions, if any, leading to immediate	b Due to (or as	a consequence	e of):								
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease of injury that initiated events											
ó	ate be executed hysician and the burial-transit	Exa	resulting in death) Last	Due to (or as	a consequence	e of):								
8760,	ate be hysici the bu	licai		d										
x 68	The law requires that the death certifica ate has been signed by the attending ph bage 2 should be detached for use as th	by Physician/Med	IF FEMALE:	23c. If yes, outcome	of pregnancy							224 D	ate of delive	
Вох	eath c attender	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal deal		Ectopic pre					1	onth	Day Year
o.	the d y the ached	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown										
Δ.	s that ined to e deta	y Pl	Part II. Other significant conditions	s contributing to death b	ut not resulting	in the ur	nderlying ca	use give	n in Part I		23e. Did to	bacco use co	ntribute to th	ne cause of death?
Vital Records,	w require been sig should b										1 🗆 Y	es 2 No	3 Prob	ably 40nknown
ဝင္ပ	law re as be 2 sh	Completed									24a. Was autop	SV	prior to cor	psy findings available apletion of cause of
<u>=</u>	The cate h	Con									perfor 1 ☐ Yes		death?	2 □ No
Vita	Physicien: this certific ral director.	Be	25. Was case referred to medical examiner?	Hospital:				Othe	-		(Check only o			Assisted
ō	ding Physicien: The lav h. After this certificate has funeral director. page 2	1: To	1 ☐ Yes 2 ☐ No  27. Manner of Death	28a. Date of Inju	ent 2 ER/C	. Time of		Bc. Injury Work	4 🗆 140			ence CO		1 living
on	Attanding r death. sctor: After by the fune	tior	1 Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month, Da	y Year)	Injury	м		? ∕es 2□	No				
Division	Attar ector by th	ertification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ad   200. Place of III	ury - At home, c. (Specify)	farm, str	eet, factory,	office		28	3f. Location (S City or Tow		ber or Rura	I Route Number,
Ö	ital or rs afte ei Dir	Ceri		January, 4										
	To the Hospital or Attanowithin 24 hours after death To tha Funerel Director:	edical		Physician: To the best caminer: On the basis of and manner st	f examination a									
	To the within To the comp	ž	29b. Signature and title of certifier						number			29d. Date sign		
ł	1		nisnegi	in				<u> 1)5</u>	75			lune	= 28	1, 2004
	V		30. Name and address of person w									e, M		
			31. Date filed (Month, Day, Year)		vetere ar's Signature	n	3 176	47,	n	ille	soll	e, M	0 21	108
	Sta Registi		JUN 2 9 20		- L	9	Spar	1/2/	,					
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DHMH 17 Rev 1/2001

			For	State of	f Maryla	nd / Depa				and M	lental Hy	/giene	<del></del> 3			
			1 - State Registrar			Cei	rtificate	e of E	Death		2. Date of D	Reg. No	200	14	201	129
ı	Physici	an	Decedent's Name (First, Middle	le, Last)							Month	Da		Yeer	3. Time (	. M
\	/Medic	al	Viola  4a. Facility Name (If not institutio	n give street and n	mher)			reer	Location o	of Death	June				4:5	ōa.
	Examin	er	1000	_	inoory		,		7 <b>ill</b>				alti		_	
	Funeral		715 Sturgis 5. Social Security Number	6. Sex		. last birthday)	If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of B	irth		9. Birthp	ece (State try)	or Foreign
	Director		093-12-3152	1 □ M 2 🔀 F	92	Yrs.	MOTUTS	Days	110013	IVIII I.	5-15	21Z		va.		
	and w	-	Usual Residence of Decedent  10a. State 10b. County	/	10c. C	ity, Town or Lo	cation							10	Od. Inside (	City Limits
	Maryli f eho	ò	Md. Balt	imore		Dund	alk								1 🔀 Yes	s 2□No
	hours after death with the Maryland tural, or items 23a or 28a-f ehow at Examinet must be notified at	Director	10e. Street and Number				10f. Zip					10g. Cit	tizen of W		try?	
	h with		244 Chestnut S	Street				212					USA	A		
	ems ems	Funerai	11. Marital Status	Armed F		U.S. 13.	Was Deced If Yes, spec	lent of Hi	spanic Origin, Mexican	gin? (Sp. i, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race Black	- Americ , White, e		
36	or it	by Fu	1 ☐ Never Married 2 ☐ Mar 3 🛣 Widowed 4 ☐ Divorce	If Yes G	2 XNo		1 ☐ Yes 2	2 🔀 No	Specify:				Specify:	Bl	ack	
Õ	72 hours 'natural', oleal Exe		15. Deceder	nt's Education		16a. Dece	dent's Usua	I Occupa	ition			16b. K	ind of Bus	siness/Inc	lustry	
215	드 교육	plet	(Specify only higher Elementary/Secondary (0-12)	est grade completed, College	1-4or 5+)	(Give	kind of wor DO NOT us	rk done d se retired;	uring mosi )	t of work	ing	Ba.	lto.	Co.		
212		Completed	6th grade			Cu	stodia	an							catio	n
nd	be filed tal Hygi d other event, I	Be	17. Father's Name (First, Middle,	, Last)		_		İ	18. Mothe	er's Name	e (First, Middle		bbott			
yla	Men Men arke	ျ	George  19a. Informant's Name/Relation.	chin (Tuna Print)	Mos	sley	na Address	(Street a	Emma ad Numbe		al Route Num				Code)	
Maryland 21215-0036	d 2 s th ar 7 is trau		Barbara Brown	Daug	hter	}	-				ltimor			1244		
	t Health tem 27 other tr		20a. Method of Disposition		20b.	Place of Dispo	osition (Nan	ne of ther place	9)	- 1	Date	20c. L	ocation - C	City or To	wn, State	
E O	0 = 5		1 X Burial 2 ☐ Cremation '4 ☐ Donation 5 ☐ Other (		State	Arbutus		_		6-30	-04	Art	outus	, M	đ.	
Baltimore,	artri orts inju		21. Signature of Funeral Service	Licensee		2: M	2. Name an	d Addres	s of Facilit	y st						
8	Dep any onc		Dlady	, Wan	0	1	101_	East	No:	rth	Ave,		timo	re		21202
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that st only one cause on	each line.	1 -	_						0		Approxima Interval Be Onset and	tween
>	Physician		Immediate Cause (Final disease or condition resulting in death)	aC	HRO	NIC	12	5 N	141	- 4	FAIL	0/4	2		YE	AR
	/Medical Examiner		resolving in death)	Due to	(or as a conse	equence of):	ZNS	11/	12	R12	NOVE	18/12	h AT	2	151	1401
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to	(or as a conse	equence of):						Di	SEM	89	1)	7 0000
•	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	<b>1</b>	7T1+1	3 RC	)SC	LE	RO	151	2				40)	EARS
ó,	te be executed ysician and e burial-transit	Exa	resulting in death) Last	Due to	(or as a conse	equence of):	. 5	1	BW	116	1				50"	YAC
3760,	e % e	lical		d. 14	91-6	CK L	-11	עו	211	<u>\                                    </u>	,				J •	1100
x 68	The law requires that the death certificate be the has been signed by the attending physic page 2 should be detached for use as the b	Physician/Med	IF FEMALE:	23c If yes o	utcome of preg	nancv							23d. Date	of delive	n/	
Вох	attend for us	cian	in the past 12 months?	1 Live	birth 2 □ Fe mant at time of	tal death 3[	Ectopic pr Other (sp						Mon		Day	Year
o.	the d	nysi	1 ☐ Yes 2 No 9 ☐ Unknown	9□ Unk	nown											
٣.	res that the de signed by the a be detached f	by P	Part II. Dther significant condit	tions contributing to	death but not re	sulting in the u	inderlying c	ause give	n in Part I	100	,				e cause of	
Records,	w require been sig should b		T T	EMIN	01-	CHA	20 10	1 0 +	110	1736	10	Yes 2	□No 3	3 Prob	ably 4 2	Onknown
ecc	e law re has be je 2 sh	Completed	120	60 A	RIU	1211					24a. Wa aut	s an opsy formed?	pr	ior to cor	sy findings	s available cause of
E R		Con	DE	MENT	A, 5	ENIL	<u>-E</u>				1 ☐ Yes	2 No		eath?	2□ No	
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medic examiner?	Hospital	/	7.50.0		Othe	200		h (Check only		0 TO:	. 10:6		
of	Phys r this ral dii	. To	1 Yes 25 No	1	of Injury onth, Day Year)	☐ ER/Outpatie 28b. Time o		28c. Injury Work		rsing Ho	28d. Describe		6 Other		7	
Division	Attending F r death. ector: After by the funes	ation	1 Satural 5 Pend 2 Accident inves	ling (Mo tigation	nth, Day Year)	Injury	М		(? Yes 2□	No						
Vis		tifica	3 Suicide 6 Could deter	mined 200. Place	e of Injury - At	home, farm, st	reet, factory	y, office			28f. Location City or To	(Street ar		r or Rura	Route Nu	nber,
Ö	ital or rs afte al Dir led in	Certification:														
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director:	Medical	(Check only 2 Medica	ing Physician: To the Examiner: On the	ne best of my ki basis of examii nner stated.	nowledge, deat nation and/or ir	th occurred evestigation	at the tim , in my op	ie, date an pinion, dea	id place, th occur	and due to the red at the time	e cause(s e, date an	) and man d place, ai	iner as st nd due to	ated. the cause	(s)
	To the within 2 To the complet	Med	29b. Signature and title of pertif		TITIET Stated.		290	c. License	number			29d. Da	ite signed	(Mopth, I	Day, Year)	
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	h		30 Name and address of perso				Print)	)	, , 1 -	- 0	1	10	#	BI	TUTIA	TOPE
_	9		HAMANAG	OPALAN	עווו נ	SEA:	ST 1d	OL	7170	4 (9	coss Ro	AD.	115	9 1	MD2	1228
	St Regist	ate	31. Date filed (Month, Day, Yea JUN 2 9	2004	Registrar's Sig	pature	and I									
	ricgisi	TUI	N V		•	-										

DHMH 17 Rev 1/2001

			1 - For State Registrar	•	epartment of Health and I Certificate of Death	Mental Hygie Reg.		201.00
			Decedent's Name (First, Middle, Last)			2. Date of Death	C O O 4	3. Time of Death
	Physici		FRANCES	EARLEAN	GARDNER	and a	Day Year 2004	14 .55 PM
7	/Medio Examin		4a. Facility Name (If not institution, give st.		4b. City, Town, or Location of Death		4c. County of Death	
			HARBOR HOSPI-	TAL CENTER	BALTIMORE		BALTIN	IORE
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birtho	Months   Davs   Hours   Min.	8. Date of Birth (Month, Day, Ye	9. Birthpla	ace (State or Foreign
	Director		0/17-22-7/01	M 21AF / Yrs	S.	NOV, 25,	1925 MAI	RYLAND
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town o	or Location	,	10	Od. Inside City Limits
	Maryl f sho	5	MADVILLE N	10 12	ALTIMORE C	ITV		1 Nes 2 No
	the t	rect	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Count	ry?
	3a or	<u></u>	1628 MORE	LAND AVENUE	51216		11.5A.	
	ms 2	Funeral Director			13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - America	
5-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "naturel", or items 23a or 28e-1 show or other traumatic svent, the Madical Examinar must be mailted at	þ	1 ☐ Never Married 2 🕅 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 Ø No II Yes, Give Year or Dates:	1 ☐ Yes 2 🛣 No Specify:	o Hican, etc.)	Specify:	ACK
Š	2 hou	ted	15. Decedent's Educa		ecedent's Usual Occupation Give kind of work done during most of wor	ting 16b	. Kind of Business/Ind	ustry
	within 7 iene. than "n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	fe. DO NOT use retired)	king -	- 1 1	2.
2121	filed with Hygiene. ther thai	000	12 THGRADE		HOMEMAKE	R	OWNI	to ME
pu	be file ital Hy id oth svent	Be (	17. Father's Name (First, Middle, Last)	~ ~ ~ ~	18. Mother's Nan	ne (First, Middle, Maid		
yla	Ment Ment arkec	္	JAMES	EPR	5 ALICE	MAG	KNIG	
Maryland	2 short and h		19a. Informant's Name/Relationship (Type		failing Address (Street and Number or Ru	ral Route Number, Ci	ty or Town, State, Zip (	Code)
	1 and 3 Health tem 27		CHARLES GARDNE		28 MORELAND	Date 200	Location - City or Tov	2/2/6
9	ges 1 t of H If ite or ot		20a. Method of Disposition 1	movar from State	isposition (Name of crematory or other place)		1	
altimore,	permit. Page Department Important: If any injury or 20058.		`4 □ Donation 5 □ Other (Specify)				ALTIHORE	
Bal	Depariment Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department		21. Signature of Funeral Service Licensee	11 Mains	22. Name and Address of Facility BA	EgWNJR		1 HOME
	ADE & C		23a. Part1. Enter the disease, or complic	etions that sourced the death. Do not	2140 N. F-ULTO,		PALTO, M.	Approximate
			shock, or heart failure. List only one	cause on each line.				Interval Between Onset and Death
7	Physician		Immediate Cause (Final disease or condition resulting in death)			nction		12 his
н	/Medical Examiner			Due to (or as a consequence of)  As in ratio				24 his.
н		<u></u>	Sequentially list conditions, b.	Due to (or as a consequence of)				
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Acuta (	renal failure			
	execu n and al-tra	Exal	that initiated events c. resulting in death) Last	Due to (or as a consequence of)				
8760,	icate be executed physician and s the burial-transit		d.					
9	ifficat g phy as th	Physician/Medical	-					
Вох	that the death certific ed by the attending p detached for use as	2	23b. was decedent pregnant	c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death	3 Ectopic pregnancy		23d. Date of deliver	•
m.	deatl	icla 1	in the past 12 months? 1 ☐ Yes 2 ☑ No	4 Pregnant at time of death	5 Other (specify)		Month [	Day Year
P.O.	The law requires that the tite has been signed by thogge 2 should be detache	hys	9 🗆 Unknown	9□ Unknown				111
	w requires that s been signed to should be det	by P	Part II. Other significant conditions cont	ributing to death but not resulting in th	ne underlying cause given in Part I.		co use contribute to the	/
ğ	aquire en siç	ed				1 🗌 Yes	2 □ No 3 □ Proba	bly 4 ⊠űnknown
ည္မ	e law re has be je 2 sho	Completed				24a. Was an autopsy	24b. Were autop	sy findings available
č	The la ate ha page 2	Ę				performed 1 ☐ Yes 2 ☐	? death?	
ita	ysicien: Th is certificate director, pag	Bec	25. Was case referred to medical examiner?			th (Check only one)		
<b>&gt;</b>	S S =	T _o	1 Yes 2 No	spital: 1 Inpatient 2 ER/Outpa	atient 3 DOA Other: 4 Nursing H	ome 5 🗆 Residence	e 6 □Other (Specify)	
0	ding Phi th. : After thi funeral	Ë	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Tim		28d. Describe how in	njury occurred	
Ö	Attending r death. ector: After by the fune	atic	2 Accident investigation		M 1 ☐ Yes 2 ☐ No			
Division of Vital Records,	of or Attencater death	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	281. Location (Street City or Town, St	t and Number or Rural tate)	Route Number,
	To the Hospital or Attenwithin 24 hours after deat To the Funerel Director: completely filled in by the	edical C	29a. Certifier 1 Certifying Physic (Check only one)	cian: To the best of my knowledge, c er: On the basis of examination and/o and manner stated.	death occurred at the time, date and place or investigation, in my opinion, death occu	, and due to the cause rred at the time, date	e(s) and manner as sta and place, and due to	ted. the cause(s)
	o the	Me	29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month, D	ay, Year)
	->-0		NV ShanGhap (PC		RES OOI		JUNE 24	, 200 L
	U		30. Name and address of person who con	INTERNAL MED	/pe, Print)			
			NITA SHANBHAG (Pay II	RESIDENT IN MEDICINE	) HARBOR HOSPITAL , 30	OI SOUTH HAN	WER STREET, B	ALTIMORE MD-
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature				
	Regist		11111 0 0 00	14 Margan B	harles			
DH	MH 17 Rev 1/2	001	JUN 2 9 201	J4 SARAGES NO.				

				State of Maryland / Department of Health and Mental Hygiene  1- State Registrar  Certificate of Death  Reg. NO 1 1									
				Registrar  1. Decedent's Name (First, Middle, Last)					2. Date of Dea	Reg, N6.)			
		Physici		Mary Catherine	Gillease				Month	Day	2004 10:31	М	
		/Medio Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Dea				th	4c. Count	y of Death			
		LXamii		Mariner Heal	th of B	Al AIR	Bel	AIR		Ha	rford		
		Funeral		5. Social Security Number 6. Sex		(In yrs. last birth	Months Days			Year)	Birthplace (State or Country)	Foreign	
		Director		213-30-6031	M 2√F	101 Yr	s.		Oct. 27	, 1902	Maryland		
		and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town o	or Location				10d. Inside City	/ Limits	
		Idf yidfild ZIZIS-0050 2 should be filed within 72 hours after death with the Maryland and Mental Hygene. In and Mental Hygene. In an extead other than "naturel", or iteme 23e or 28e-f show reumatic event, it is Madical Examinational Conditional.	ō	Maryland Harford		Bel Ai	r				1 ☐ Yes	2 <b>2</b> (No	
			rec	10e. Street and Number		DC1 111	10f. Zip Code		1	0g. Citizen of	What Country?		
			0	1405 Saratoga Driv	e		2101	4		USA			
			Funeral Directo	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. Was Decedent of If Yes, specify Cu	Hispanic Origin? (S	Specify Yes or No- to Rican, etc.)		ce - American Indian, ack, White, etc.		
	98	or its	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 🌠 N If Yes, Give	0	1 ☐ Yes 21X No		, , , , , , , , , , , , , , , , , , , ,		_{fy:} White		
	15-003	in 72 hours n"neturel!, Mulicul Ext	ed by	3 Widowed 4 □ Divorced	Year or Dates:	162 D	ecedent's Usual Occi	unation			Business/Industry		
			Completed	15. Decedent's Educ (Specify only highest grade	completed)	((	Give kind of work doni fe. DO NOT use retir	e during most of wo	orking	16b. Killa ol E	ousiness/industry		
	212	with iene.	шо	Elementary/Secondary (0-12)	College (1-4or 5-		er/Operato	or		Restau	ırant		
	Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 7 Department of Healeth and Mental Hygiene. importent: if item 27 is marked other than " any injury or other treumetic event, Ite Med once.	To Be C	17. Father's Name (First, Middle, Last)		'		7	me (First, Middle, i	Maiden Suma	me)		
				Stephen (NMN) Ga	ttus			Marie	(NMN)	Kapisa	ık		
	/Jar	2 sho and h is ma		19a. Informant's Name/Relationship (Ty) George T. Binko, J			lailing Address <i>(Stree</i> 5 <b>Sarato</b> ga						
	e)	1 and 1eelth im 27 ther ti		20a. Method of Disposition	1. 5011		isposition (Name of				- City or Town, State		
	آور	ages nt of h :: If ite		1 □ Burial 2 □ Cremation 3 □ R	emoval from State	cemetery,	crematory or other pl				k, Maryland		
	Iţi	artmer artmer ortent injury		<ul> <li>4 □Donation 5 □ Other (Specify)</li> <li>21. Signature of Funeral Service Ucense</li> </ul>			<u>_</u>			Duridas	st, raryrana		
	Ba	Dep imp		Mules a m	he /		McComas Fi			n Mar	771and 21009		
		Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or peach line.  Approximate Interval Between									
				Immediate Cause (Final disease or condition  Alzhim(v)  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian  Jingingian									
	1			resulting in death)	Due to (or as a	consequence of)		V 1 1 1 1			7.4.	. )	
	и	Examiner		Sequentially list conditions									
		pe tis	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of)	•						
12		ate be executed only sician and the burial-transit	хаш	that initiated events resulting in death) Last	Due to (or as a	consequence of)	•			<del> </del>			
\	8760,	be ey ician buria	a		200 10 (0. 200		•						
a)	687	death certificate e attending phys ed for use as the	dlcal										
56	×		√M¢	IF FEMALE: 2	3c. If yes, outcome of					23d. Da	ate of delivery		
Image: Color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of t	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1								Month D		ear .		
0	0	w requires that the s been signed by th 2 should be detache	ted by Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown								
11/20	ords, F			Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death?			
(0)									1 🗆 Ye	1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknow			
	ecord		Completed						24a. Was a autops	V	Were autopsy findings av	vailable use of	
c 1	H	The page	Con						perform		death? 1 ☐ Yes 2 ☐ No		
$\bigcirc$	of Vital	il or Attending Physicien: The la after death. Director: After this certificate ha d in by the funeral director, page 2	Be	25. Was case referred to medical examiner?	ospital:				ath (Check only on				
$\rightarrow$			2	1 195 21110		g Home 5 Residence 6 Other (Specify)  28d. Describe how injury occurred							
7			lon	27. Manner of Death  1/3 Natural 5 ☐ Pending	uryat ork? ⊒Yes 2 ⊒No	28d. Describe flow injury occurred							
2	ivision		flca	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number,							er,		
7	Div	after Direction	Certification:	4 Homicide		City or Town, State)							
		To the Hospitel or within 24 hours afted To the Funerel Dirric completely filled in I	edical C	29a. Certifier (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
		the hin 24 the F the F	Medi	one)		29d. Date signed (Month, Day, Year)							
		29b. Signature and title of certifier  29c. License number  29d. Date signature											
	7	1.		// // // // // // // // // // // // //		<u>/</u>	Do Briet)	2701		- June 25, 2004 The Mary ) and 21014			
		Ψ		30. Name and address of person who co	mpieted cause of de	North	Avinu1	B1 ) h	IN M.	6 pm ) "	nd 2101	Y	
		Sta	ite	31. Date filed (Month, Day, Year)	32. Registra					1/1			
		Poniet	ar	11 N 9 0 2004	5	-a 4		,					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. Ne. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 2004 17:40 Kaitlyn Marie Grimes June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Sinai Hospital Baltimore 8. Date of Birth (Month, Day, Year)
April 21, 2004 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months 2 Days 1 □ M 2X F Hours Director 216-69-6711 Maryland Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 123s or 28e-f show N/A Baltimore 1 XYes 2 No Maryland by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2703 Christopher Ave., Apt. A 21214 United States death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after cannot of Health and Mental Hygiene.
ant: if item 27 is marked other than "natural; or Iten any or other than than the familian in yor other thaumatic event, Its Mealies 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: white 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) n/a n/a 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Kristina Bailin Acurtiss Grimes 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2703 Christopher Ave., Apt. A Baltimore, MD 21214 Kristina Bailin/mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Department of Importent: If i eny injury or once. Holly Hill Cemetery June 28,2004 Middle River, Maryland 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc.
MD 21212 21. Signature of Funeral Service Licensee 6500 York Rd. Baltimore, MD 21212 23a. Parl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, brock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a con) equence of): **Examiner** Sequentially list conditions, if any, leading to immediate the leading to immediate the leading to immediate the leading to the leading that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: JSe 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 🗖 No Ö 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed: death? certificate 1 Yes 2 No 2 No Division of Vital To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 反 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 2 🗌 No XXYes this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation 1 Natural Deceased Struck 2:30 P 1 ☐ Yes 2 🛣 No death. 6-20-04 2 Accident Director: 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Z 703 Christopher And. 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined after nome Apt. A. Factimone, MD 21214 124 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifig O.C.M.E. June 24, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1706 A1 111 Penn Street, Baltimore, Maryland 21201

State Registrar 31. Date filed (Month, Day, Year) JUN 2 9 2004

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2004 June **Physician** 25 Sr. M. ANTIONETTE HOUGH, MHSH /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Rodgers Forge Baltimore County The Villa 7. Age (In vrs. last birthday) If Under 1 8. Date of Birth (Month, Day, Year) Birthplace (Stete or Foreign Country) 6. Sex 5. Social Security Number **Funeral** Min Days 1 □ M 2 🛱 F Months Hours 220-52-6250 **Director** Aug 17, 1913 Virginia 90 Usuel Residence of Decedent death with the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Funeral Director Maryland Baltimore County Rodgers Forge 10e, Street and Number 10g. Citizen of What Country? 6806 Bellona Avenue 21212 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates: filed within 72 hours after 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 Widowed 4 Divorced "natural", Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed withir nent of Health and Mental Hygiene. int: if item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Religious Nun Christian Ministry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Louis E. Hough Ellen R. Hobbs 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sr. Loretta Cornell, MHSH 1001 W. Joppa Road, Towson, Maryland 21204

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 'Department of H Important: If ite eny injury or of once. 1 M Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cemetery 6/30/2004 Baltimore, Maryland 22. Name and Address of Facility 21. Signature of Function Service License e Mitchell-Wiedefeld Funeral Home, Inc. Martin D. Lawson Martin D. Lawson 6500 York Road, Baltimore, Maryland 21212

23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Congestive **Physician** /Medical Due to (or as a consequence of) **Examiner** obstructive Chronic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Be Completed by Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed palema that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death Day in the past 12 months? Month Year 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No detached Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 JUnknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 ☐ Yes 2 ☐ No 25 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification; To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Natural 5 Pending investigation 1 Yes 2 No death. 2 Accident hours after death the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 04 0 DV 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 120

DHMH 17 Rev 1/2001

State

Registrar

mone

JUN 2 9 2004

31. Date filed (Month, Day, Year)

oaks

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrer	State of Maryla		ment of Health iicate of Deati		ental Hygien Reg. No		0.01
	Physic /Medi		Decedent's Name (First, Middle, Last House	, L	HARRI	S		2. Date of Death Month Da	<del>- 1111</del>	3. Time of Death 4:50A M
	Examine Funeral Director	ner	4a. Facility Name (If not institution, give  NORTHWEST HO  5. Social Security Number  6. Se  22() - 20() 20(9)	spital	s. last birthday)	Under 1 Year If Under onths Days Hours	alst		County of Death	place (State or Foreign
	<u> </u>	tor	Usual Residence of Decedent  10a. State  10b. County	nore,	ity, Town or Locati	Nosvilla		3-20-1		0d. Inside City Limite 1 ☐ Yes 2 12 No
	ath with the 23a or 28e ust be noti	Funeral Director	10e. Street and Number A204 MUFORD N	VIII Road		of. Zip Code 212()	8	10g. Cit	tizen of What Cour	•
0.36	72 hours after death with the Maryland natural, or items 23a or 28e-f show dical Examinat must be notified at	þ	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in I Armed Forces? 1  Yes 2  No If Yes, Give Year or Dates:	If Ye	Decedent of Hispanic C s, specify Cuban, Mexico Yes 2 2 No Specify	an, Puerto H	ify Yes or No- ican, etc.)	14. Race - Americ Black, White, Specify:	ean Indian, etc.
7	within ane. then "	Completed	15. Decedent's Edu (Specify only highest grad	cation e <i>completed)</i> College (1-4or 5+)	(Give kind	s Usual Occupation tof work done during mo NOT use retired)	est of working	16b. K	ind of Business/Ind	dustry
	should be filed in the standard Mental Hygis smarked other the smarked other the smartic event, It	To Be (	17. Father's Name (First, Middle, Last)		(unki	iwn) Hilo	ta Rt	First, Middle, Maiden	m	
	es 1 and 2 sho of Health and if item 27 is ma ir other trauma		19a. Informant's Name/Relationship (Ty ESTELLA Grant 20a. Method of Disposition	(COUDIN)	310 C	ddress (Street and Numb Combridge) n (Name of	Day Day	e, Baltin	or Town, State, Zip Ore M pocation - Only or To	0 21244
	permit. Pages Department of I Important: If it, any injury or o once.		1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens	GO GO	rrison Fo	rest me and Address of Faci		)4 Owi	nas Mil	18. MA
	nysician /Medical Examiner	er	23a. Part 1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	cations that caused the deale cause on each line.  Due to (or as a consection).  Due to (or as a consection).	quence of):	e mode of dying, such a	s cardiac or i	respiratory arrest,		Approximate Interval Between Onset and Death
,00,00	physician and sthe burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec	quence of):	FU INFE	670	N .		
O. DO.		Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 25 No 9 Unknown	3c. If yes, outcome of pregn. 1 □ Live birth 2 □ Fete 4 □ Pregnant at time of c	al death 3 Ecto	pic pregnancy er (specify)		2	23d. Date of deliver Month	y Day Year
r (cp.ic	been signed b	by	Part II. Other significant conditions con	tributing to death but not res	ulting in the under	ring cause given in Part	l.	23e. Did tobacco u		6 K
	ate ha	Completed	OF Was appropriately					24a. Was an autopsy performed?	prior to com death?	sy findings available pletion of cause of
5 6	fter this	ation: To Be	25. Was case referred to medical examiner? 1  Yes 2 No  27. Manner of leath 1 Natural 5 Pending investigation	ospital: Innpatient 2  28a. Date of Injury (Month, Day Year)	ER/Outpatient 38 28b. Time of Injury	DOA Other: 4 No 28c. Injury at Work?	ursing Home 28d	Check only one)  5  Residence 6  Describe how injury		
Iloration Affording	within 24 hours after death. To the Funeral Director: After	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specif	y)			Location (Street and City or Town, State)		
the Hoer	hin 24 hor the Fune npletely fi	Medical	one)	ician: To the best of my kno ler: On the basis of examina and manner stated.	wledge, death occi tion and/or investig	ation, in my opinion, dea	nd place, and oth occurred	due to the cause(s) at the time, date and	and manner as sta place, and due to t	ted. he cause(s)
F	wit cor		29b. Signature and title of certifier	wp.		29c. License number D4397	7	29d. Date	signed (Month, D	ay, Year)
	Star Registra	te	30. Name and address of person who core with the filed (Month, Day, Year)	30) Hash (Item 32) Registrar's Signa	BRIVE C	THEN BLANGE	- 475	200		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Stete Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 200^{Year} June 25 12:30 A M Hornbarger Kathleen Vada 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. Oct. 11, 1923 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Months 1 ☐ M 2 🛣 F 80 Virginia 226-30-4278 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2 ☐ XNo Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21040 USA 2205 Willoughby Beach Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 X No Specify: 3 ₩Widowed 4 Divorced White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James K. Comer Martha (nmn) Foster 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2205 Willoughby Beach Rd., Edgewood, Maryland 21040 Joe Hornbarger 20a. Method of Disposition

1★ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Cokesbury UMC Cemetery June 30,2004 Abingdon, Maryland * 4 □ Donation 5 □ Other (Specify) 21. Signatur of Fund al Service Licensee 22. Name and Address of Facility
McComas Funeral Home 1317 Cokesbury Rd., Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ubarachnoid emorrhage 6 h15 Due to (or s a consequence of) Due to (or as a consequence of):

Pnysician /Medical Examiner

ō Department of Important: If any injury or once.

Physician

/Medical

Examiner

**Funeral** 

Director

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or Itams 23a

al Hygiene.

Pages 1 and 2 should be finent of Health and Mental Healt: If Item 27 is marked of

Director

Be Completed by Funeral

other traumatic event, the Medical Examiner must be notified at

the Maryland

filed within 72 hours after death

Baltimore, Maryland 21215-0036

68760

Box

Vital Records.

the Hospital or Attending

death.

within 24 hours To the Funaral

Kathleen

Hornbarger

the death certificate be executed

Examine use as the burial-transit Physician/Medical þ Completed Be 10 Certification: Diractor:

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE:

23b. Was decedent pregnant

in the past 12 months? 1 ☐ Yes 2 ☑ No

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4☐Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

2 No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy

perform 1 ☐ Yes

3 ☐ Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

Year

25. Was case referred to medical examiner? examiner? 1 Tes 2 No Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 2 Accident 5 Pending investigation

determined

2 XER/Outpatient 3 □ DOA 28b. Time of Injury

28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certif

Marco

3 Suicide

29a Certifier

4 Homicide

(Check only one)

29c. License number

29d. Date signed (Month, Day, Year)

June 25, 2004

auce tamere 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Zamera

500 Upper Chosapeake Drive, Bel Air, Maryland 21014

State Registrar

Medical

31. Date filed (Month, Day, Ye JUN 2 9 2004

MD

32. Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year George Cowen Holmes P. M. JUNE 1:10 2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SAINT AGNES BALTIMORE, MARYLAND FUnder 1 Year If Under 24 Hrs. 8. Date of Birth HEALTHCARE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours Min. 1 XM 2□ F 220-20-4085 77 Yrs 12, 1926 Maryland Aug. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 Yes 2 No Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 414 Chalfonte Drive 21228 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Types 2 No If Yes, Give Year or Dates: 1944–1946 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mechanical Contractor Steamfitter 10th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Cora Ruth Cowen William Edward Holmes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1811 Millridge Court; Annapolis, Maryland 21401 Claire G. Von Karls-Niece 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 06/28/04 Baltimore, Maryland 22. Name and Address of Facility Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licensee M00869 1630 Edmondson Avenue; Catonsville, Maryland 212 Part 1. Ententhe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) ACUTE MYOCARDIAL thirty-six hours Due to (or as a consequence of): SEPTICEMIA thirty -six hours OBSTRUCTIVE AND RESTRICTIVE LUNG DISFASE Eight months 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 XYes 2 No 3 Probably 4 Dunknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? HEART ISEASE 2. No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)

**Examiner** The law requires that the death certificate be executed Box 68760 Records, P.O. this certificate Vital Attending Physicien: funeral director, After Division filled in by the Director: Hospitel or To the Hospitel within 24 hours a To the Funerel L

Hermen

**Physician** 

/Medical

Examiner

**Funeral** 

Director

Items 23a or 28e-f show

Directo

Funeral

Completed by

treumatic event, the Medical Examiner must be notified at

Department of H Importent: If Ite any injury or of <u>2005e</u>.

**Physician** 

/Medical

Pages 1 and 2 should be filed within 72 hours after death inent of Health and Mental Hygiene. Int: If Item 27 is marked other then "neturel", or Items 23

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical IF FEMALE 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à Completed VALVULAR 25. Was case referred to medical examiner? Be Hospital: 1X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification; To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending Injury investigation 1 Tes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

enmo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

29b. Signature and title of certified

Day.

3449 WILKENS AVENUE SUITE 300 BALTIMORE, MARYLAND 21229 JONATHAN SAFREN M.D. 32. Registrar's Signatur

ATTENDING CAS PRODUCTION

MARYLAND

D0041711

29d. Date signed (Month, Dav. Year)

JUNE 25, 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year William L. Jackson, Sr. JUNE 2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death OSPITAL ALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 7-17-39 9. Birthplece (State or Foreign Country)

N.C. 7. Age (In yrs. last birthday, 213-34-5136 64 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. Baltimore M☐Yes 2☐No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 5701 The Alameda 21239 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8th grade Foreman/Supervisor Allied Signal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)

20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Zion Cem.

Cora

5701 TheAlameda, Baltimore, Md.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6-26-04

BAKTIME, MO ZIZ39

Lee

Jackson

21239

20c. Location - City or Town, State

Lansdowne, Md.

Jackson

Wife

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Itema 23a or 28a-1 show ury or other traumatic event, the Medical Examinating to notified a Baltimore, Maryland 21215-0036 permit. Pages 1
Department of H
Important: If Itel
any injury or ott

**Physician** 

/Medical

Examiner

Director

Funeral

Completed by

Be

2

Lester

Sarah Jackson

20a. Method of Disposition

TERRANCE

31. Date filed (Month, Day, Year)

JUN 2 9 2004

19a. Informant's Name/Relationship (Type, Print)

4 Donation 5 ☐ Other (Specify)

1 Burial 2 ☐ Cremation 3 ☐ Removal from State

**Funeral** Director

**Physician** /Medical **Examiner** 

The law requires that the death certificate be executed burial-transit as the esn jo the Hospital or Attending Physician: ctor: After this of the funeral dir after death Director: filled in by

Division of Vital Records, P.O. Box 68760

21. Signature of Funeral Service Licens	6-			Address of Facility F.H. East	llOl E. M	ore, Ma. North Av	
23a. Part1. Enter the disease, or complishock, or heart failure. kist only on	cations that caused the deat e cause on each line.						Approximate Interval Between
Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conseq	VD		· · · · · · · · · · · · · · · · · · ·			Onset and Death
Sequentially list conditions, if any leading the record of the cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consec	trance of):		·			
resulting in death) Last	Due to (or as a conseq	uence of);					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	I death 3 E	Ectopic preg Other (spec			23d. Date of d Month	lelivery Day Year
Part II. Other significant conditions con		ulting in the und	lerlying cau	se given in Part I.		o use contribute	to the cause of death?  Probably 4 Junknow
					24a. Was an autopsy performed	prior to	autopsy findings availab completion of cause of es 2 No
25. Was case referred to medical examiner?				26. Place of De	eath (Check only one)		
1 ☐ Yes 2 No	ospital: 1 Inpatient 2	ER/Outpatient	3 DOA	Other: 4 Nursing	Home 5 Residence	6 ∏Other (Sn	necify)
27. Manner of Death  1 Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c	i. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in		cony,
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, stree	t, factory, c	office	28f. Location (Street City or Town, St.	and Number or F ate)	Rural Route Number,
29a. Certifier Certifying Physic (Check only one)	icien: To the best of my kno- er: On the basis of examinat and manner stated.	wledge, death o tion and/or inve	occurred at stigation, in	the time, date and place my opinion, death occ	ce, and due to the cause curred at the time, date a	(s) and manner a and place, and du	as stated. ue to the cause(s)
29b. Signature and title of certifier	Laker 1	70	29c. L	icense number	-	Date signed (Mor	oth, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

within 24 hours a To the Funerel C

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 LOCH AVEN BUCGVER

Cocked Name   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Column   Colum				1 - For State Registrar	State of	Marylan	id / Depa		t of H	lealth a		ntal Hygie	_	) L	20438
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FFEMALE   23b. Was decedent pregnant   Live birth   2   Female   23b. Was decedent pregnant   Live birth   2   Female   23b. Was decedent pregnant   Live birth   2   Female   23b. Was decedent pregnant   Live birth   2   Female   23b. Was decedent pregnant at time of death   3   Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   23b. Chercippe   2	60,	be ex		<b>3</b>	Due to (or	as a consequ	ience or);								
Part II. Other signature and fine of certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause () and manner stated.    State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   Stat	387	phys phys s the			d										
Part II. Other signature and fine of certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause () and manner stated.    State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   Stat	×	certif nding use as	/Me		23c. If yes, outco	me of pregnar	ncv								
Part II. Other signature and fine of certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause () and manner stated.    State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   Stat	B	death atter	clar	in the past 12 months?	1 ☐ Live birth	n 2 ☐ Fetal	death 3								•
1   Yes 2   No 3   Probably 4   Onknown  24a. Was an autopsy performed? 1   Yes 2   No 3   Probably 4   Onknown  24a. Was an autopsy performed? 1   Yes 2   No 3   Probably 4   Onknown  24a. Was an autopsy performed? 1   Yes 2   No 3   Probably 4   Onknown  25. Was case referred to medical examiner?  10   Yes 2   No 3   Probably 4   Onknown  25. Place of Death (Check only one)  26. Place of Death (Check only one)  27. Manner of Death (Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably 1   Probably	0	the cachec	hysl					(9)	,,						
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State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   Stat	ğ	quire an sig uld b										1 🗌 Yes	2 □ No	3 🔲 Proba	ably 4 Junknown
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State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   Stat	Œ.	The late ha	mo:							-	_	performed	? pr	ior to com	pletion of cause of
State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   State   Stat	ia	stan: artifica ctor.	0							26. Place of			140		2   100
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State  286. Location (Street and Number or Rural Route Number, City or Town, State)  287. Certifier (Check only one)  288. Place of Injury - At home, farm, street, factory, office determined  289. Place of Injury - At home, farm, street, factory, office of City or Town, State)  286. Location (Street and Number or Rural Route Number, City or Town, State)  287. Location (Street and Number or Rural Route Number, City or Town, State)  288. Location (Street and Number or Rural Route Number, City or Town, State)  288. Location (Street and Number or Rural Route Number, City or Town, State)  289. Certifier (Check only one)  290. Certifier (Check only one)  291. Certifier (Check only one)  292. Signature and view of certifier (Check only one)  293. Signature and address of person who completed cause of death (Item 23a) (Type, Print)  Eddie Nakuda, MD, 2300 Dulaney Valley Road, Timonium, Maryland 21093  31. Date filed (Month, Day, Year)  32. Registrar's Signature		ing P	.uo	_	28a. Date of I (Month,	njury Day Year)		28			28d. I	Describe how is	jury occurre	d	
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and address of person who completed cause of death (Item 23a) (Type, Print)  Eddie Nakuda, MD, 2300 Dulaney Valley Road, Timonium, Maryland 21093  31. Date filed (Month, Day, Year)  32. Registrar's Signature  329a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and the time, date and place, and due to the cause(s) and manner as stated.  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Eddie Nakuda, MD, 2300 Dulaney Valley Road, Timonium, Maryland 21093	<u>s</u>	tend leath tor: /	cat	2 ☐ Accident investiga	t be			-		es 2□No					
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and address of person who completed cause of death (Item 23a) (Type, Print)  Eddie Nakuda, MD, 2300 Dulaney Valley Road, Timonium, Maryland 21093  31. Date filed (Month, Day, Year)  32. Registrar's Signature  329a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and the time, date and place, and due to the cause(s) and manner as stated.  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Eddie Nakuda, MD, 2300 Dulaney Valley Road, Timonium, Maryland 21093	-	F 8 F C	iti		ed   28e. Place of	Injury - At hor , etc. (Specify)	m <b>e, farm</b> , stre )	et, factory,	office		28f. L	ocation (Street City or Town, St	and Numbe ate)	r or Rural	Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Eddie Nakuda, MD, 2300 Dulaney Valley Road, Timonium, Maryland 21093  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	_	spital ours : ieral filled	<u></u>	29a. Certifier 12 Cartifuing	Physician: To the h	act of my know	yledge deet	000:::::	e els = e'	n data : 1	alaas : i i		· · · ·		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Eddie Nakuda, MD, 2300 Dulaney Valley Road, Timonium, Maryland 21093  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature		24 h 24 h 8 Fur etely	dice		diminer. Off file past	S OI OXAIIIIIAII	ion and/or inv	estigation,	in my opi	e, date and p inion, death o	occurred at	the time, date	i(s) and man and place, ar	ner as sta nd due to	ited. the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Eddie Nakuda, MD, 2300 Dulaney Valley Road, Timonium, Maryland 21093  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature		To th within To th compl	Me		/			29c,	License	number		29d.	Date signed	(Month, D	ay, Year)
Eddie Nakuda, MD, 2300 Dulaney Valley Road, Timonium, Maryland 21093  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	)			) Vale	4012	del!		1	//	550	3 8				
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		h		30. Name and address of person wi	no completed cause (	of death (Item	23a) (Type, F	Print)							
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		9		Eddie Nakuda	, MD, 2300	Dulan	ey Val	ley R	load.	Timor	nium.	Marvla	nd 210	93	
				31. Date filed (Month, Day, Year)	32. Regi	istrar's Signatu	red.								

			1 - For State Registrar	State of M	/larylar		artmen rtificat			nd M	R	eg. No. (	004	20439
	Physici	an	1. Decedent's Name (First, Middle, Elvine	Last) Richard		77 d o.					<ol><li>Date of Dea Month</li></ol>	Day	Year	3. Time of Death
	/Medi		4a. Facility Name (If not institution,		el	King		T		( Do not	June	22	2004	7:38 P M
	Examir	ier	Montgomery Gene				40. City,	O1r	Location of	Death			inty of Death	
	Funeral			3. Sex 7. A	lge (In yrs.	last birthday)	If Under	1 Year	If Under 2	4 Hrs.	8. Date of Birth	1		nplace (State or Foreign untry)
ı,	Director		579-62-5200	1□ M 2\\ F	83	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day July 31	$\frac{1920}{1920}$		sachusetts
	and		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside City Limits
	Mary f sho	tor	Maryland Montgo	mery		•	Ro	ckvi	.11e					1 X Yes 2 No
	h the	Director	10e. Street and Number				10f. Zip	Code			1	0g. Citizen	of What Cor	untry?
	within 72 hours after death with the Maryland ene. than "natural", or itams 23a or 28e-f show fra Medical Examinar must be rollified at	aiD	4413 Muncaster	Mill Rd.				20	853			Unit	ed Sta	ates
	tams	uner	11. Marital Status	12. Was Deceden Armed Forces	?	J.S. 13.\	Vas Deced	dent of Hi	spanic Origi n, Mexican,	in? (Spec	cify Yes or No- Rican, etc.)		Race - Amer Black, White	
36	rs afte	by Funerai	1 ☐ Never Married 2 ☐ Marrie 3 🕅 Widowed 4 ☐ Divorced	d 1 ☐ Yes 2 📉 If Yes, Give Year or Dates:	_		I □ Yes :		Specify:		, ,			√hite
9	2 hou	ted t	15. Decedent's	Education		16a. Deced	lent's Usua	d Occupa	ıtion				f Business/li	ndusta.
215	thin 7.	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or	5+)	(Give	kind of wor DO NOT us	rk done a	lurina most a	of workin	lg	TOD. IVAII O	Dusinessyn	ndustry
2	filed with Hygiene. othar thai	Con		2			Arti	st				Self	-Emp1	oyed
nd	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28e-f show other traumatic event. I've Medical Examinar must be retiffed at	Be	17. Father's Name (First, Middle, La		Richa						(First, Middle, M		,	
Maryland 21215-0036	2 should be and Mental is marked o	2	August  19a. Informant's Name/Relationship		KICH				Het				enway	
M	id 2 si Ith an 27 is r traur		David Rankine /						nd Number S <b>t.;</b> R		Route Number	City or Tov 9509	vn, State, Zi	p Code)
ē,	s 1 an f Heal itam 2 other		20a. Method of Disposition		20b. F	Place of Dispos cemetery, cren				Da	ato .		n - City or T	own State
9	Page: ent of nt: If i		1 ☐ Burial 2 🕅 Cremation 3  3 4 ☐ Donation 5 ☐ Other (Spe			esapeak Sapeak				une 2004	28		•	le, MD
Baltimore,	permit. Pages 1 and 2 Department of Health s Important: If itam 27 is any injury or other tra			nsee	1	The second second					emation			ie, m
<u> </u>	825 2 3		It stepley of	mem	M003	<b>782</b> 9	33 Gi	st A	ve.,	Silv	er Spri	ng, M	ices D 20	910
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	mplications that cause by one cause on each	ed the deat line.	h. Do not ente	er the mode	e of dying	, such as ca	ardiac or	respiratory arre	est,		Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	_a Acu	ite Co	oronary	Inst	ıffic	iency	,				Onset and Death 15 minutes
	/Medical Examiner		resulting in death)	Due to (or as										0.57 55
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as		stitis				_			_	2 weeks
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events											
ó	an an	Еха	resulting in death) Last	c Due to (or as	s a conseq	uence of):								
8760,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial transit	dicai		d										
9	ertific ling p	Med	IF FEMALE:										I	
Вох	leath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Feta	I death 3	Ectopic pre						Date of deliver	ery Day Year
o.	the de	ysic	1 □ Yes 2 🔯 No 9 □ Unknown	4□Pregnant a 9□Unknown	it time of a	eatn 5∐	Other (spe	ecity)						Suy Tour
Δ.	res that the de igned by the a be detached f	by Pr	Part II. Other significant conditions	contributing to death t	out not res	ulting in the un	derlying ca	iuse givei	n in Part I.		23e. Did tob	acco use co	ntribute to t	he cause of death?
rds	w requires been sig should be										1 ☐ Yes	s 2 No	3 🗆 Prot	oably 4 Unknown
Vital Records,	aw re	Completed									24a. Was an		. Were auto	ppsy findings available
ř		E O						-		_	autopsy perform	ed?	prior to co death? 1 Yes	mpletion of cause of 2 □ No
/Ita	sician: Th certificate rector, paç	Be (	25. Was case referred to medical examiner?						26. Place of	f Death (	Check only one		1 1 1 1 0 3	20110
01	Attending Physician: r death. ector: After this certific by the funeral director.	70	1 ☐ Yes 2 📉 No			ER/Outpatient		Other	4 🗌 Nursi	ing Home	e 5 ☐ Resider	nce 6 🗆 O	ther (Specif	iy)
חכ	ding l h. After funer	ion	27. Manner of Death 1 ☒ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury y Year)	28b. Time of Injury	28 M	lc. Injury i	at	28	d. Describe how	v injury occi	urred	
Division of	ol or Attendi after death. I Director: A d in by the fu	fica	2 Accident investigat 3 Suicide 6 Could not	be Oss Bless of In-	iurv - At ho	ome, farm, stre			es 2∏No	-	If Location (Stre	and Num	shor or Dum	l Route Number,
	P Pige	Certification;	4 Homicide determine	building, et	tc. (Specif)	()	ot, ractory,	Onice		20	City or Town,	State)	IDEL OF HITE	ir Houte Number,
	la Hospitel 124 hours a la Funerel I	edical C	29a. Certifier (Check only one)  1   Certifying   2   Medical Ex	Physician: To the best aminer: On the basis o and manner st	n examina	wledge, death tion and/or inve	occurred a estigation,	t the time	, date and p nion, death	occurred	d due to the cau l at the time, dat	use(s) and note and place	nanner as si	tated. the cause(s)
	Yo tha Ho within 24 I To tha Fu completely	Me	29b. Signature and title of certifier	4				License			29	d. Date sign	ed (Month,	Day, Year)
•	1		Devett M	Carrier n	1)			D476	82			Jun	e 24,	2004
	6		30. Name and address of person wh											
			Bennett Morriso				ndy S	prin	g Rd.	, 01	ney, MD	2083	32	
	Star Registra	ie ar	on Date Gentlewitz, 1997, 20074	32. Registr	ar Signa	Coant	,							

DHMH 17 Rev 1/2001

Court

		1 - For Stata Registrar			Health and Mental H	ygiene Reg. No. 004	20441
-	Physician /Medica	1. Decedent's Name (First, Middle, L Baby Girl Luca			Month	12, 2004 Year	3. Time of Death 7:15 PM M
	Examiner	4a. Facility Name (If not institution, go Southern Mary	ive street and number) land Hospital	4b. City, Town, Clinto	or Location of Death  n	4c. County of Dea	
	Funeral Director	none	Sex 1 ☐ M 2 X F	last birthday) If Under 1 Year Months Days	Hours Min. June	Birth (9. Bi (2004) 9. Bi (2004) 9. Bi (2004) M	thplace (State or Foreigr ountry) [aryland
	Ba-f show	Usual Residence of Decedent  10a. State 10b. County  MD Prince		y, Town or Location Temple Hills			10d. Inside City Limits 1 ☐ Yes 2√ No
	th with the 23a or 2	10e. Street and Number 3620 Dixon Stree	t	10f. Zip Code	20748	10g. Citizen of What C	•
	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than *natural', or Itams 23a or 28a-f show any riqury or other treumetic event, the Medical Exercitivat: satisfy inciding an once.		12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	S. 13. Was Decedent of I If Yes, specify Cub	dispanic Origin? (Specify Yes or an, Mexican, Puerto Rican, etc.)  Specify:		
	Ind 21215-0036 be filed within 72 hours at lat Hygiene. d other than "natural; or event, the Medical Eventy Re-Completed by E	15. Decedent's (Specify only highest g	Education rade completed) College (1-4or 5+)	16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	pation during most of working d)	16b. Kind of Business	/Industry
9	212 d with giene gratha	none	none	none		none	
14	Maryland d 2 should be file the and Mental Hy Tris marked oths treumetic event,	17. Father's Name (First, Middle, Las Alvin Lucas	st)		18. Mother's Name (First, Mide Lisa William		
	Mary	19a. Informant's Name/Relationship Southern Marylar			and Number or Aural Aoute Nur Road Clinton,		Zip Code)
40/	Baltimore, permit. Pages 1 at Department of Heal mportent: If Item any injury or othe pice.	20a. Method of Disposition  1 □ Burial 2 □ Cremation 3  1 □ Donation 5 🖸 Other (Spec	I Hellioval irolli State	lace of Disposition (Name of emetery, crematory or other pla	Ce) Date	20c. Location - City or	Town, State
holalon	Baltir Permit. P Departme Importen any injur	2 Signalus of Euneral Services Ico			ess of Facility Comy Board 655 V MD 21201	. Baltimore	Street
*	760, Ita be executed Wedical Examiner For Examiner		b. Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)	uence of):  SC QVY  uence of):	ng, such as cardiac or respirator	arrest,	Approximate Interval Between Onset and Death
las	O. Box 68' ne death cartificat the attending phy hed for use as the		23c. If yes, outcome of pregna 1  Live birth 2 Feta 4 Pregnant at time of de	I death 3 Ectopic pregnance	у	23d. Date of de Month	livery Day Year
3		Partin Other algumeant conditions	contributing to death but not resi	ulting in the underlying cause gr		d tobacco use contribute t	the cause of death?
3	Vital Records, iician: The law requires to certificate has been signs rector, page 2 should be.				24a. W	as an 24b. Were a	utopsy findings available completion of cause of
3	The The sate has page				pe 1 🗆 Yes	rformed? death? s 2 No 1 ☐ Yes	2 □ No
	Vital F sician: Th certificate rector, pag	25. Was case referred to medical examiner?	Hospital:		26. Place of Death (Check online):		
2	Vision of Vital Attending Physician: rdeath. setor: Atter this certifically the funeral director, by the funeral director, fifraction: To Be C		28a. Date of Injury (Month, Day Year)	28b. Time of lnjury Wo	ry at 28d. Describ	esidence 6 Other (Spe e how injury occurred	naify)
130	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	2 Accident investigati 3 Suicide 6 Could not 4 Homicide	be see Steen of Leiter At he	ome, farm, street, factory, office		a (Street and Number or R Fown, State)	ural Route Number,
	he Hospita in 24 hours he Funeral pletely filled		Physician: To the best of my kno aminer: On the basis of examina and manner stated.	wledge, death occurred at the ti tion and/or investigation, in my	me, date and place, and due to the opinion, death occurred at the time	ne cause(s) and manner a e, date and place, and du	s stated. a to the cause(s)
	To the within To the comple	29b. Signature and title of certifier	De naber	29c. Licens	33268	29d. Date signed (Mon.	h, Day, Year)
		30. Name and address of person wh	o completed cause of death (Item Vabur 75			or Md	20735
	State Registrar		32. Registrar's Signa				

DHMH 17 Rev 1/2001

Pages 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. No. U Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** JUNE  $22^{\text{pay}}$ 2004 ar SAMUEL ADAM LOSEY 10:25a м /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner JOHN HOPKINS HOSPITAL BALTIMORE CITY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/29/1994 5 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1**X**M 2□F 245-77-9323 10 Yrs. NORTH Director CAROLINA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 27 is marked other than "natural", or items 23s or 28a-f show traumatic event, the Medical Examinating the notified at 1 Yes 2 No MD BALTIMORE SPARKS Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16420 DUBBS RD 21152 USA Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: WHITE Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4YRS STUDENT EDUCATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ROBERT H. LOSEY II LINDA VOGEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT LOSEYII (FATHER) 16420 DUBBS RD SPARKS, MD. 21152. item 27 l 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of h Important: If ite any injury or of once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State SARDINIA CEMETERY06/28/2004 ERIE CO., N.Y. *4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility W. JENKINS & SONS YORK RD MONKTON, MD 23a. Part 1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underwind Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the a 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown 1 TYes Completed been 24b. Were autopsy findings available prior to completion of cause of death?

17 Yes 2 No 24a. Was an certificate has autopsy performed page 1 Yes 2 2 26. Place of Death (Check only one) 2 No Be 25. Was case referred to medical examiner' Hospital: Other: 1 Inpatient 2 ER/Outpatient 2 1 Yes 2 No 3 DOA 4 Nursing Home 5 Residence 6 ☐ Other (Specify) this 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation 404 0965 STruck by Vet 2 Accident Director: lace of njury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rur | Route Number, City or Town, State) 6 Could not be 3 Suicide 4 Homicide 601 nreu Funeral 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated.

State Registrar 29b. Signatu

31. Date filed (Month, Day, Year) JUN 2 9 2004

32 Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

To the

To the Hospital or Attending Physician: The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records.

29c. License number

OCME

29d. Date signed (Month, Day, Year)

23, 2004

JUNE

111 Penn Street, Baltimore, Maryland 21201

			1 - For State Registrar			epartment Certificate		and Mental H	ygiene Reg. No		20113
>	Physic /Medi Exami	cal	Decedent's Name (First, Middle, L.      Kang Im Lee      4a. Facility Name (If not institution, gives a lint Joseph	ve street and numbe		4b. City, To	own, or Location	of Death	Da UNE	25, 200 County of Dea	th
	Funeral Director		5. Social Security Number 6. 213-02-1564	Sex 7.	Age (In yrs. last birth	Months   1		0 W 5 0 D or 24 Hrs. 8. Date of E Min. (Month, I 1 1 / 2	Birth Da <i>y, Year)</i>	9. Bir	timore  thplace (State or Foreign buntry)  rea
	th the Maryland or 28a-f ehow e retiffed et	Director	Usual Residence of Decedent  10a. State 10b. County  VA  10e. Street and Number		South		ode	,	10g. Cit	izen of What Co	10d. Inside City Limits 1 ☐ Yes XXNo
9800	within 72 hours after death with the Maryland ene. than "naturat", or Items 23e or 28e-f ehow the Madical Examiner mast be rotified at	by Funeral	25259 Nesting  11. Marital Status  1 Never Married 2 Married  XXWidowed 4 Divorced	Square  12. Was Deceder Armed Force 1	(I No	2015  13. Was Deceder If Yes, specify	nt of Hispanic O Cuban, Mexica	rigin? (Specify Yes or N n, Puerto Rican, etc.)		SA  14. Race - Ame Black, Whit  Specify: AS	e, etc.
Maryland 21215-0036	filed Hygi thar	Completed	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12)  8  17. Father's Name (First, Middle, Las.	ade completed) College (1-4o	r 5+)	ecedent's Usual ( Give kind of work of fe. DO NOT use Homemak	done during moretired)	st of working er's Name (First, Middl	10	wn Home	
Marylan	2 should be and Mental is marked of aumatic ever	To Be	Jom Deuk Lee	Туре, Print)			Jum Street and Numb	Soon Bac	ek ber, City o	r Town, State, 2	001
Baltimore,	t. Page rtment o rtant: If njury or		Sarah Kim/daug  20a. Method of Disposition  1 Burial 2 Cremation 3 Other (Special  4 Donation 5 Other (Special	Removal from Stat (y)		wn ^P ark	orial	quare, So	Marı	ciotts	ville.Md
Bal	Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department		23a. Part1. Enter the disease, or comshock, or heart failure. List only	polications that caus	ed the death. Do not	555 Tw	in Kno	"Witzke F 11s Road,	uneı [Co	cal Hor	mes, Inc.
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)		FLE CERE		CULAR	ACCIDENTS	3		Onset and Death
8760,	rate be executed thysicien and the burial-transit	dicai Examiner	Exposition, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С	s a consequence of):						
.O. Box 6	The law requires that the death certific lie has been signed by the attending pi page 2 should be detached for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown		2 Fetal death	3 ⊟Ectopic pregr 5 □ Other (specif	nancy (y)		2	3d. Date of deliving Month	very Day Year
Records, P	w requires that been signed should be det	eted by P	Part II. Other significant conditions of CORONARY ARTERY		but not resulting in th	e underlying caus	e given in Part I	1	Yes 2		the cause of death?
Vital Rec		Be Completed	25. Was case referred to medical examiner?				26. Place	24a. Was auto perfet 1 Yes	psy ormed? 2 A No	24b. Were aut prior to co death? 1 \sum Yes	opsy findings available ompletion of cause of
ō	a t la	Certification; To	1		ury 28b. Time ay Year) Injur	e of 28c. y M	Injury at Work? 1 ☐ Yes 2 ☐ I		how injury	occurred	
DIV	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Medical Certif	29a. Certifier (Check only one) (Check only one)	ysician: To the best niner: On the basis of	oi examination and/or	eath occurred at th	ne time, date an	d place, and due to the	wn, State)		stated.
	To the within 2 To the comple		29b. Signature and title of certifier	- Fon	M.D.	29c. Lid	ense number 24034	1		signed (Mahth,	
	Sta Registr	te	30. Name and a dress of person who TTMOTHY DW M. 31. Date filed (Month, Day, Year)  JUN 2 9 2004	D. 7601	OSLER D	,	OWSON I	MARYLAND	2120		,

			For State Registrar	State of	Maryland		artment of H		Mental Hygi	iene	20111
			Decedent's Name (First, Middle,	Last)					2. Date of Death	h	3. Time of Death
	Physici /Medi		KWUN Y	ZAU LO	)				June	24, 2004	10:41P M
	Examir		4a. Facility Name (If not institution,		-		4b. City, Town, or		th	4c. County of Dea	
			Northwest Hosp  5. Social Security Number		er . Age (In yrs. Ia	et hidhdau)		llstown If Under 24 Hr	S 9 Data of Birth	Baltim	
	Funeral Director		012-52-4113	1 XM 2□F	62	Yrs.	Months Days	Hours Mir		^{Year)} 1942 C	nthplace (State or Foreign ountry) hina
	ט		Usual Residence of Decedent						F	,, -	
	show	5	10a. State 10b. County			, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 💢 No
	the M	Director	Maryland Balti	liore	UW.	ings N	11.1.1.S 10f. Zip Code		10	Og. Citizen of What C	
	3a or		4413 Winter Mil	1 Wav			211	17	,,,	U.S.A.	
	death ms 2	Funeral	11. Marital Status	12. Was Decede		S. 13. \	Was Decedent of His f Yes, specify Cubar	~ .	Specify Yes or No-	14. Race - Am	erican Indian,
9	or Ite	/Fu	1 ☐ Never Married 2X Marrie	Armed Force 1 Yes 2 If Yes, Give	<b>Y</b> No	}	r Yes, specify Cubar I ☐ Yes 2 💢 No	Specify:	rio Hican, etc.)	Black, Whi	
Ö	72 hours after death with the Maryland natural', or Items 23a or 28a-1 show dical Evantraer must be rediffed at	ed by	3 Widowed 4 Divorced	Year or Date	es:						inese
21215-0036	n nai	Completed	15. Decedent's (Specify only highest	grade completed)		(Give	lent's Usual Occupa kind of work done d DO NDT use retired)	uring most of wo	orking	6b. Kind of Business	s/Industry
212	e filed within al Hygiene. I other than " vent, the Me	mo	Elementary/Secondary (0-12) 12 years	College (1-4	or 5+)		Proprieto	or		Restaur	ant
pu	m - 0 5	Be (	17. Father's Name (First, Middle, La	est)				18. Mother's Na	me (First, Middle, M	faiden Sumame)	
Maryland	should be nd Mental marked o	2	unk	- (T D-i-4)		400 14 10		unk			
Ma	2 8 8 7		19a. Informant's Name/Relationshi Koon Ying Ng	g (Type, Print) (wif	Pe)		Winter Mi			City or Town, State,	yland 21117
ē,	s 1 and 2 f Health Item 27 i		20a. Method of Disposition		20b. Pla	ace of Dispos	sition (Name of natory or other place	1 1 2 2		Oc. Location - City or	
Ë			1 XBurial 2 ☐ Cremation 3  14 ☐ Donation 5 ☐ Other (Spe		ate	•	Cemetery	· I	27, 2004	Woodlawr	n, Maryland
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Li	censee		22 N	Name and Address	s of Facility	d Funoral	Home, In	o individual
-	207 29		Searge J. Fres	ran		6	500 York	Road E	altimore.	_Maryland	21212
ŀ			23a. Part 1. Enter the disease, or c shock, or heart failure. List or	nly one cause on eac	ine.		n 1 1	(	-x - 4		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	-			Cardiou	ascular	Disease	, , , , , , , , , , , , , , , , , , ,	5 years
	Examiner			Due to (or	as a conseque	ence of):					
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Gualto (or	as a conseque	erioù Uf)r					
	cate be executed physician and the burial-transit	Examiner	that initiated events	c							
8760,	be exectan a	ai Ex	resulting in death) Last	Due to (or	as a conseque	ence of):					
387	physicate by the b	dicai		d							
Вох	death certific e attending p id for use as I	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						23d. Date of de	livery
	death ne atte	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		h 2 ∏ Fetal o nt at time of dea		Ectopic pregnancy Other (specify)			Month	Day Year
P.0	that the de ed by the detached	Phys	9 Unknown								
	se gu	by	Part II. Other significant condition	s contributing to deat	th but not result	ting in the un	iderlying cause giver	n in Part I.			o the cause of death?
Sor	w requir been si should	etec									
Vital Records,	The lay	Completed					<del></del>		24a. Was an autopsy performe	ed? prior to death?	utopsy findings available completion of cause of
ta		0	25. Was case referred to medical					26 Place of De	1 ☐ Yes 2	No 1 Yes	ZX No
Ž	S S E	To B	examiner? 1XYes 2 No	Hospital: 1 🗆 Inp	atient 2 KE	R/Outpatient	-			ice 6 Other (Spe	ocify)
n of			27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of I (Month,	Injury 2 <i>Day</i> Yea <i>r)</i>	28b. Time of Injury	28c. Injury Work	at ?	28d. Describe how	v injury occurred	
Divislon	tend leath tor: the	catl	2 Accident investiga 3 Suicide 6 Could no	t be go Diose of	Jaiwas At hom			es 2□No	006 Leasting (Ctro		
Div	P in the	Certification:	4  Homicide determin	ed 200. Fiace of building,	, etc. (Specify)	ne, rann, stre	et, factory, office		City or Town,	eet and Number or Ri State)	urai Houte Number,
_	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by		29a. Certifier 1 ☐ Certifying	Physician: To the be	est of my knowl	ledge, death	occurred at the lime	e, date and place	a, and due to the cau	use(s) and manner as	s stated.
	the Hc in 24 line Fu he Fu	edical	one) 2 Medical Es	caminer: On the basis and manner	s of examination	on and/or inv	estigation, in my opi	nion, death occi	urred at the time, dat	e and place, and due	to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	1 1	1		29c. License	number	290	d. Date signed (Mont	h, Day, Year)
	4		The state of the	1) Dabi	uty		0180	067	7	une 24	,2004
_	3		Philip Milite	no completed cause of	of death (Item 2	23a) (Type, F	Print)	T. Luth	enville. M.	aryland	21093
	Sta Registr	•	31. Date filed (Month, Day, Year) JUN 2 9 2004	32. Regi	istrar's Signatu	9 4	ooch		7	one 26	

			State of Maryland / Department of Health and Mental Hygiene  1- State Registrer  Certificate of Death  Reg. No. 201415
			1. Decedent's Name (First, Middle, Last)  2. Date of Death  3. Time of Death
	Physicia	an ⁶	Han Lafrance MASSEY June 24 2004 9.15 PM
	/Medic		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death
	Examin	er	2737 West Cafayette Street Baltimore City
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign
	Director		214 58 5336 12 M 2 F 51 Yrs. Months Days Hours Min. (Month, Day, Year) Country) A.
	pur *		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location         10d. Inside City Limits
	show	ច	MD Baltimore City Baltimore 1/2 Yes 2 100
	the A	ect	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
	3a or		2727 West Cafayette Street 21216 USA
	death ms 2	nera	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.
9	after or Ite	by Funeral Director	1 Never Married 2 Married 1 Never Short 1 No Specific Secretary
5-0036	72 hours after death with the Maryland neturel; or Items 23s or 28s-f show dissi Exaluter must be rediffed at		3 Wildowed 4 Divorced Year or Dates: 1980 - 1993
15-	n 72	lete	(Specify only highest grade completed)  (Give kind of work done during most of working life. DO NOT use retired)
2121	filed within Hygiene. other than " ant, the way	Completed	Elementary/Secondary (0-12) College (1-4or 5+) ILABORER BALTO. CITY
β	be filed tal Hygid d other evant, the	Be C	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame)
Maryland	Men Men arke	Jo.	ELLSWORTH MASSEY RUTH ALLEN
Jar	2 sho		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  CLARISSA MASSEY  2731 W. LAFAYETTE AVE., BALTO. MO 21216
	1 and 1 Health am 27 ther tr		20a Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State
5	Pages nent of int: If it		1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  ARBUTUS  cemetery, crematory or other place) 4-30-04  BALTO . MO
Baltimore			21. Signature of Funeral Service License 22. Name and Address of Facility VAUGHN C - GREENE FUNERAL SERVICE
m	permit. Departr Importu any inji		VAUBIN C. GREENE FUNDERAL SERVICE 5151 BALTO. NATI PIKE, BALTO. NO 21229
П	- P		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between
9	Physician		Immediate Cause (Final disease or condition a PNEUMONIA 3 days.
П	/Medical Examiner		resulting in death)  Due to (or as a consequence of):
4		-	Sequentially list conditions, if any, leading to immediate  b. TRING A  Due to (or 43 a consequence of).
	ured I	Examiner	cause. Enter Underlying Cause (Disease or injury
ó	exection and and rial-tra	Еха	that initiated events resulting in death) Last Due to (or as a consequence of):
8760	death certificate be executed e attending physician and ind for use as the burial-transit	dlcal	d
9	ertifica ling ph e as t	Med	IF FEMALE:
Вох	death certific attending pl	ian/	23b. Was decedent pregnant in the past 12 months?    Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Secon
O.	that the de ed by the detached	ysic	1 Yes 2 No 9 Unknown
0		Completed by Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Records,	w requires been sign should be	ed b	1 Yes 2 No 3 Probably 4 Unknown
000	aw Is b	plet	24a. Was an autopsy findings available prior to completion of cause of
- B	The ate h page	Com	performed? death?  1 Yes 2 No 1 Yes 2 No
/ita	ysician: Th is certificate director, pag	Be (	25. Was case referred to medical axaminer?
of Vital	hys this al dii	. To	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Hesidence 6 Other (Specify)  27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred
O	ling After fune	tlon	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year)  28b. Time of Injury Work?  1 Yes 2 No
Division	Attending r death. ector: After by the fune	Ifica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Ö	s after s after Director	Certification:	4   Hothicide Building, etc. (Specify)
	Hospi 4 hour Funer ely fill	ledical	29a. Certifier (Check only 2   Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  20a. Certifier (Check only 2   Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Med	one) and manner stated.  29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
	<u> </u>		Danal K. Walshe MD 1741408 Juno 25 2004
	/		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
	5		827 Linden AUE, Suite 3F. Baltimore MD 21001.
	Sta Regist		31. Date filed (Month, Day, Year)  32. Registrar's Signature  4 April 1

DHMH 17 Rev 1/2001

**ORIGINAL** 

Earl R. Monroe, Jr. 04-04180 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. cm 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month June Day 26 **Physician** EARL R. MONROE 2004 3:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death University of Maryland Medical Center Baltimore N/AIf Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country)
 MD **Funeral** 1**⊠**M 2□ F 214 · 23 · 3599 Usual Residence of Decedent Director 15 01-31-1989 the Maryland 10a. State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at MD N Directo 1 Yes 2 No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23g 2664 LAURETTA 21223 USA AVENUE death Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or lier any injury or other traumatic according. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 2 No Specify: Completed by 3 Widowed 4 Divorced Specify: BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NIA STUDENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) EARL MONROE, SR URSULA ISAAC 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ISAAC 2664 LAURETTA AVE. URSULA BALTO. MO 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State MT. XION 4 ☐ Donation 5 ☐ Other (Specify) 07.02.04 BALTO. 21. Signature of Fundal Service License 22. Name and Address of Facility
VAUGHN C. GREEVE FUNERAL SERVICE Wan 5151 BALTO. NATE PIKE, BALTO MO 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Gunshot wound of head Friyaician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncert, in Cause (Disease or injury Due to (or as a consequence of): Examiner transit and that initiated events resulting in death) Last the attending physician a hed for use as the buriat Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Completed

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 □ No

Year

 $A^{M}$ 

examiner? 1 XYes 2 □ No 27. Manner of Death 1 Natural 2 Accident

3 Suicide

(Check only one)

Be

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Medicai

25. Was case referred to medical

5 Pending investigation

28a. Date of Injury (Month, Day Year) 6/26/04

Hospital: 1 | Inpatient 2 | XER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) 28b. Time of Injury 2:30 AM

28c. Injury at Work? 1 ☐ Yes 2 No

28d. Describe how injury occurred subject shot

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Street 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number Ave. City or Town, State) 2604 Laure Ha Ave. Baltimore MD

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Jaske ? Yrends 30. Name and address of person who com and ed cause of death (Item 23a) (Type, Print)

asha Z Greenber

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

June 26, 2004

31. Date filed (Month, Day, Year) Registrar JUN 2 9 2004 Registrar's Signature

M.D

Sporks

To the Hospitel or Attending

within 24 hours after death.

To the Funeral Director: Al
completely filled in by the fu

filled in by

		-	For State Registrar	State of Maryla	•	artment of H			giene Reg. No.	nnı	201.1.7
	Physicia	an	1. Decedent's Name (First, Middle, Las	100 Re, SR				2. Date of De Month	-	Year 7/10 4	3. Time of Death
>0	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death	3010		County of Deatl	
	Exami	Ĭ	406 SHADE TREE P				NSVICE				MORE
I	Funeral Director		5. Social Security Number 6. Social Security Number 1	SIM 2 TE	S. last birthday)  Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da	y, Year)	Co	nplace (State or Foreign untry)
	pug *		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or L	ocation					10d. Inside City Limits
	Maryk -1 sho lieu u	tor		MORE	CAT	ONSVILL	e				1 ☐ Yes 2 XNo
	th the or 28a s noti	irec	10s. Street and Number			10f. Zip Code			10g. Citiz	en of What Co	
	ath wi	ral	406 SHADE TREE				1228			U.S.	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itams 23a or 28a-f show important: If Item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, I'm Medical Examination until to molified at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates:	U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☒ No	ispanic Origin? (S in, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		4. Race - Ame Black, White Specify: B	e, etc.
5-0036	2 hou	ted I	15. Decedent's Ed (Specify only highest gra	lucation	16a. Dece	dent's Usual Occup	ation	tking	16b. Kin	d of Business/	Industry
2	rithin 7	Be Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done of DO NOT use retired	-	9	N!4	ewsp4	1Dep
d 2	filed w Hygiel Ather then then the	Co	12th grade   17. Father's Name (First, Middle, Last)	NIA		ACILITA		ne (First, Middle,			
an	Aental Aental rked o	To B	ALFONSO M	oore			IDA 1	Mej	ACK	Moz	
Maryland 2121	and 2 should ealth and Men n 27 Is marke isr traumatic		19a. Informant's Name/Relationship (MARY E. MU	_							(ip Code) 21228 ALTO, MD
altimore,	ss 1 ar		20a. Method of Disposition		. Place of Disp cemetery, cre	osition (Name of matory or other place	:e) [	Date		cation - City or	
Ĕ	Pages ment of t		1 ☑ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify	<i>(</i> )	ARBU	-		•			re, ud
Balt	permit. Departr Imports any inju		21. Signature of Funeral Service Lider	see	2	2. Name and Addre	ss of Facility	Ne FUR	JERA	- ser	Vices
			23a. Part 1. Enter the disease, or com	plications that caused the de						- 1340	Approximate Interval Between
Ş	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition	Metas	tatio	Rectal	Cano	ev			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cons	equence of):	,					
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a cons	sequence of):						
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c							
90,	cate be executed oblysician and the burial-transit		resulting in death) Last	Due to (or as a cons	equence of):						
	physic physic s the b	dlca		d							
Вох 6	eath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pred 1 ☐ Live birth 2 ☐ Fi		□Ectonia pragnasa			2	3d. Date of deli	,
O. B.	The law requires that the death certific tie has been signed by the attending p page 2 should be detached for use as	Physician/Medical	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 Pregnant at time of 9 Unknown		□Ectopic pregnancy □ Other (specify) _				Month	Day Year
<u>α</u>	res that the signed by be detacted		Part II. Dther significant conditions of	ontributing to death but not i	resulting in the	underlying cause grv	en in Part I.	23e. Did t	obacco us	se contribute to	the cause of death?
rds	w requires been sign should be	ed by						1 🗆	Yes 2	No 3□Pr	obably 4 Unknown
eco	e law requ has been je 2 shoult	Completed						24a. Was	DSV	prior to o	topsy findings available completion of cause of
Vital Records,									rmed? 2 X No	death?	2□ No
	Physician: r this certific ral director,	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ♠ No	Hospital: 1 ☐ Inpatient 2	: ☐ ER/Outpatie	int 3□ DOA Oth		ath (Check only o		□Other (Spec	cify)
ا م	ding Phy h. After this funeral c		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	28b. Time			28d. Describe			
Sion	tan leat lor: the	catle	2 Accident investigation 3 Suicide 6 Could not b			M 1 🗆	Yes 2 □ No	ORA Lagration /	Cton et ann	( Number of C	- Courte Alumbas
Division	al or Attands after death at Diractor:	Certification:	4 Homicide determined		t home, farm, si ecify)	treet, factory, office		City or To	street and wn, State)	i Number or Hi	iral Route Number,
2	To the Respital or At within 24 hours after of To the Funaral Dirac completely filled in by	edical (		niner: On the best of my land manner stated.							
	To the Vithin 2.	Me	29b. Signature and title of certifier	Aus. V. 1	11D	29c. Licens	e number	2	29d. Date	signed (Mont)	h, Day, Year)
)	P		1 pull	journer "	· · ·	D	18387		Ju	n 29	2004
ŀ	>			completed cause of death (I	tem 23a) (Type	4 Ave	Bal	HIMOVE	e u	112 2	2004
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Si	gnature	South	/				

			1 - For State Registrar	State of Maryla		artment of H		_	/giene	0L 20L	Ι. Ω
	Physici		Decedent's Name (First, Middle, La	Charlotte	Louise	McGovern		2. Date of De Month June	Day	3. Time of D	
7	/Medid Examir		4a. Facility Name (If not institution, giv	e street and number)	· · · · · · · · · · · · · · · · · · ·	4b. City, Town, or	Location of Deat		4c. County		<u> </u>
			Good Samaritan H	ospital		Balt	imore Ci	.ty	N	I/A	
2	Funeral Director		216-20-2370	ex 7. Age (In y. ☐ M 2 <b>½</b> F 77	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Oct. 2	rth ay, Year) 4,1926	Birthplace (State or Country)     Maryland	Foreign
	72 hours after death with the Maryland natural", or items 23e or 28e-1 show also I Examiner must be notified at	Director	Usual Residence of Decedent   10a. State	timore 10c.	City, Town or Lo	10f. Zip Code	Dund	alk	10g. Citizen of V	10d. Inside City 1 Yes 2	
	h with	O IE	101 Centre Pla	ce Apt. 408		2	1222		Unite	d States	
9036	s within 72 hours after death with the Marylan liene. r then "natural", or items 23s or 28s-1 show the Madical Examinet must be notified at	d by Funeral I	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2€3No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes 2 □ No	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	o- 14. Race Blac Specify	e - American Indian, kk, White, etc.	
21215-0036	within 72 h iene. 'then "natu I'm Medical	Completed	15. Decedent's Ed (Specify only highest grades) Elementary/Secondary (0-12)		(Give	dent's Usual Occupa kind of work done d DO NOT use retired,	furing most of wor )	king	16b. Kind of Bu	usiness/Industry	
2	Hygier Hygier ther th		7 Years			Homemaker			Own		
Maryland	a la b	To Be	17. Father's Name (First, Middle, Last, William H. Wate	ers				otte Mat	tzdorf	θ)	
	7 12		19a. Informant's Name/Relationship ( William W. Selle:	rs (Son)	5015	ng Address (Street a East Bid					21205
Baltimore,	Pages 1 and nent of Health ant: If item 2: ury or other t		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other Specifi	Removal from State		natory or other place		Date 6/28/2		City or Town, Stete	MD
Balti	permit. Pages Department of Important: If i any injury or once.		21. Si nature Fineral Service Len	the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s	22	Name and Address Duda-Ruck 7922 Wise	s of Facility Funeral	Home of	f Dundal	k, Inc.	
>	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused the de one cause on each line.	eath. Do not ent	er the mode of dying	g, such as cardiac	or respiratory a	disean	Approximate Interval Betwee Onset and De	en ath
Ď	/Medical Examiner	-	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a cons	ve	Heart	Faile	ne			
	te be executed ysicien and ie burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a cons	etes						
8760,	cate be e physicien the buria	cal	(	d. Chris		enal	msu	ffice	oncy		
P.O. Box 68	the death certificate be executed y the attending physicien and iched for use as the burial transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date Mon	e of delivery hth Day Yea	ar
	wrequires that the de been signed by the should be detached	þ	Part II. Other significant conditions of	7-	-	nderlying cause give	n in Part I.			ibute to the cause of dea	·
Division of Vital Records,	The lar	Completed	0						osy pr ormed? de	Vere autopsy findings avarior to completion of cause eath?  ☐ Yes 2☐ No	ariable se of
/ita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only o	one)		
5	Physician: this certific ral director,	2	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2			4 U Nursing H	ome 5 Resid	dence 6 🗆 Othe	r (Specify)	
sion (	fter	Certification:	27. Manner of Death  1 Natural 5 Pending  2 Accident investigation  3 Suicide 6 Could not be		28b. Time of Injury	28c. Injury Work' M 1 □ Y	at ? ′es 2 □ No	28d. Describe h	how injury occurre	ed	
Divi	ital or Att rs after d al Direct	Certifi	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spe	home, farm, str	eet, factory, office		28f. Location (S City or Tow	Street and Numbe vn. State)	r or Rural Route Number	r,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Furneral Director: After this certific completely filled in by the funeral director,	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my k niner: On the basis of exami and manner stated.	nowledge, death nation and/or inv	occurred at the time restigation, in my opi	e, date and place, inion, death occur	and due to the cred at the time, or	cause(s) and man date and place, ar	nner as stated. nd due to the cause(s)	
	To T com	Σ	29b. Signature and title of certifier	And	MD		51464		6/20	(Month, Dey, Year)	
_	9		30. Name and address of person who SHOALB A. HAS	HM1, 821	em 23a) (Type, N , Eu	Print) St	Smite	308,	Baltin	muse MI)	2/20
	Sta Registr	te ar	31. Date filed (Month, Day, Year) JUN 2 9 2004	22. Registrar's Sig	nature	4,					

			1- For State Registrar	of Maryland		rtment of H			00	0 !	20110	
			Decedent's Name (First, Middle, Last)			inioato or i	Journ	2. Date of Deati	g. Nø.		3. Time of Death	-
	Physici /Medi		Betty Gene McI	ntyre				Month June	21,	Year 2004	7:28 P	М
	Examir		4a. Facility Name (If not institution, give street and	number)		4b. City, Town, or	Location of Death		~ · · · ·	y of Death		_
			Suburban Hospital			Bet	hesda		Mot	ntgom	ery	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthp	place (State or Foreigntry)	gn
	Director		216-44-3780 1LM 2MF	00	Yrs.			Sept. 6,			gínia	
	/land		10a. State 10b. County	10c. City, T	own or Loc	ation				1	0d. Inside City Limit	ts.
	Man B-f sh	ţċ	Maryland Montgomery			Beth	esda				1 X Yes 2 □ N	io
	ath with the Marylan 23e or 28e-f show	Directo	10e. Street and Number			10f. Zip Code		10	g. Citizen of	What Cour	ntry?	_
	23e	<u>e</u>	10910 Old Georgetown Ro	1.			20817		Unite	d Sta	ıtes	
	iter dea	Funeral	Armed	ecedent Ever in U.S. Forces?	13. V	as Decedent of Hi Yes, specify Cuba	spanic Origin? (Spe n, Mexican, Puerto I	cify Yes or No- Rican, etc.)		ce - Americ		
36	al', or	by F	If Yes,	s 2 🔯 No Give r Dates:	1	☐ Yes 2🌠 No	Specify:		Specia		hite	
9	"netural"		15. Decedent's Education	11	6a. Deced	ent's Usual Occupa	ation		6b. Kind of 8			
215	thin 7 en "n	ple	(Specify only highest grade complete Elementary/Secondary (0-12) College	d) (1-4or 5+)	(Give H	rind of work done d O NOT use retired,	luring most of workir )	ng i		4011100041110	lustry	
21	filed within 72 hours after death with the Maryland Hygiene. Uther then "netural", or Items 23e or 28e-f show ent, the Marical Examinational be notified at	Completed	12		Dire	ctory of	Persone1		Custon	s Off	ice	
_	0 = 0 >	Be	17. Father's Name (First, Middle, Last)  Bernard Garland	D.	w.o		18. Mother's Name			,		
Σ̈́	hould d Mer marke marlc	ပ	19a. Informant's Name/Relationship (Type, Print)		rown	1	Laura	Virgin		Snook		
⊠	id 2 s Ith an 27 is r		Robert Williams / Grand				nd Number or Rura St.NW; Wa					
re,	s 1 an i Hea item		20a. Method of Disposition	20b. Place	of Dispos	ition (Name of	Di	ate 2	Oc. Location	200 City or To		
3	Page ent o nt: If ry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal fro  4 ☐ Donation 5 ☐ Other (Specify)	III JIAIU		atory of other place e Cremato	June	29				
P28AM Baltimore, N	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other treumatic a <u>pnce</u> .		21. Signature of Funeral Service Licensee	M00382			s of Facility al and Cr				le, MD	
4	8918		Stephe D Lolinean		93	3 Gist A	ar and Cr ve., Silv	emation er Sprin	Servio	ces 2091	10	
0			23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause or		o not ente	r the mode of dying	, such as cardiac or	respiratory arres	it,		Approximate	
	Physician		Immediate Cause (Final disease or condition resulting in death)	therosc	len	the co	Schovas	scular	disc	cap ,	Onset and Death	
	/Medical Examiner		Due t	o (or as a consequenc	ce of):					0.	/	9
-	- 4	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	o (or as a consequenc	ce of):							
6/21/04 88760,	outed id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							-		
000	an an	Exa		o (or as a consequenc	ce of):							
[6/12 8760,	icate be executed physician and the burial-transit	dical	d									
Ψ.	certific Iding p Ise as	/Med	IF FEMALE:									
Box	death certifi e attending pod for use as	clan/Me	in the past 12 months?	outcome of pregnancy birth 2 Fetal dea gnant at time of death		ctopic pregnancy				te of deliver	ry Day Year	
, o	0 0 0	Physic	1 Yes 2 No 4 Pre 9 Unknown 9 Unk		5 🗀 1	Other (specify)					July Tour	
No.	s that the ned by th e detache	by Pr	Part II. Other significant conditions contributing to	death but not resulting	g in the und	lerlying cause giver	n in Part I.	23e. Did toba	cco use cont	ribute to the	e cause of death?	
- p	w requires that been signed b should be det							1 ☐ Yes	2 🗆 No	3 🔲 Proba	ibly 4 hknown	1
	law re as bee 2 sho	ompleted						24a. Was an	24b. \	Vere autop	sy findings available	
	9 2 9	Com						autopsy performe	d?	prior to com death?	sy findings available apletion of cause of	
り 語	certificate rector, pag	Be C	25. Was case referred to medical examiner?				26. Place of Death			1103 4		
5		္ရ	1 Yes 2 No Hospital: 1 □		Outpatient	3☐ DOA Other	4 Indising Hom	e 5 Residen	e 6 □Oth	er (Specify)		
	fter	lon:	1 Natural 5 Pending (Mo	e of Injury onth, Day Year)	. Time of Injury	28c. Injury Work?	?	ld. Describe how	injury occurr	ed		
isi	Attending r death. sctor: After by the fune	licat	2 Accident investigation 3 Suicide 6 Could not be	ce of Injury - At home,	form atro-		es 2 No	If I posting /Chr.	- 4 4 4	0		_
D S	after Dire	Certification:	4 Homicide determined 256. Para buil	ding, etc. (Specify)	iaim, stree	в, тастогу, опісе	28	If. Location (Stree City or Town,	stand Numbi State)	er or Rural	Houte Number,	
	spita hours inerel y filled		29a. Certifier 1 Certifying Physician: To the	ne best of my knowled	lge, death (	occurred at the time	a, date and place, an	d due to the cau:	se(s) and ma	nner as sta	ted	
	n 24 he Fu he Fu	edical	(Since on) 2   Medical Examiner. On the	basis of examination a inner stated.	and/or inve	stigation, in my opi	nion, death occurred	at the time, date	and place, a	ind due to t	he cause(s)	ŀ
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Σ	29b. Signature and title of certifier			29c. License	number	29d	. Date signed	(Month, D	ay, Year)	
			· you	us		D5	5410	1	6/2	1/0	)4	
	1		30. Name and address of person who completed ca	use of death (Item 23a	(Type, Pr	int)	d Ges		0	1 13	eshoda lup zoz	
	-Cla	•	31. Date filed (Month, Day) Year) 2 2 32.	Registrar's Signature	1 8	60004	u ous	grow	n pa	1, 1	no rox	19
	Sta Registra	-	JUN 2 9 2004	Selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the select	J.	Grank				-		/

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	sician edical		re E	lmund M	loore		T			2. Date of I Month May 2	22,	Day Yea 2004	1802 p *
	niner	4a. Facility Name (If not St. Mary 15. Social Security Numb	s Hospi	tal	ge (In yrs. la:	et hiethele	Leo	Town, or nard	Location of D LOWN		Ì	4c. County of De St. Mai	ry's
Funer Direct		236-19-0 Usual Residence of Dec	754 19	\$M 2□F	38	Yrs.	Months			Hrs. 8. Date of E (Month, I NOV •	21,	1965	inthplace (State or Foreig Country) WV
deeth with the Maryland me 23s or 28a-f show rnust be notified at	ctor	10a. State 10t	St. Ma	ırys	10c. City,		Location anic	svil	1e				10d. Inside City Limits
ith with the 23s or 28	al Director	10e. Street and Number 42154	Ridge	Road			10f. Ziş	2065	9		10g.	Citizen of What C USA	Country?
<u>a</u> ≗ 5	by Funeral	11. Marital Status 1 Never Married 3 Widowed 4		12. Was Decedent Armed Forces 1 Yes 2 M If Yes, Give Year or Dates:	?	. 13	I Was Dece If Yes, spe 1 Yes	cify Cuba	spanic Origin' n, Mexican, P Specify:	? (Specify Yes or I uerto Rican, etc.)	No-	Black, Wh	nerican Indian, nite, etc. Thite
21215-0036 ad within 72 hours at gions to than "netural", or the Madical Example.	Completed	15. (Specify of Elementary/Secondar 1.2	Decedent's Edu nly highest grad y (0-12)	cation le completed) College (1-4or		(Giv	edent's Usua ve kind of wo DO NOT u	rk done d se retired,	luring most of )	working		Kind of Busines	
and 2 d be filed initial Hygi- sed other	Be Co	17. Father's Name (First Theodo)		Moore					18. Mother's	Name (First, Midd		len Sumame) a Ann	Lanham
Maryland od 2 should be file lith and Mental Hy lith and Mental Hy re in marked other recomments event	ျို	19a. Informant's Name/ Rebecca	Relationship (T)	rpe, Print)	c	19b. Mai	iling Address	(Street a	nd Number o	r Rural Route Num		y or Town, State,	Lanham Zp Code)
Baitimore, Sermil. Peges 1 ar Separiment of Hea Mopriant: if Item: my Injury or othe		20a. Method of Dispositi 1 SpBurial 2 Cr 4 Donation 5 C	emation 3-05		C.	eger	cosition (Nar	(political	Ma	5/04 ₆ <del>y 29</del> 004	20c. Bu Me	Location - City of Ckhannor	Town State 1. WV 26201
Bait permit. Departr imports	once	21. Signature of Funera	08.3	rig			Char 1501	les Eas	s of Facility L. St t For	evens F t Ave B	alt	eral Ho	me Inc. Md. 21230
Physicia /Medic	al	23a. Part1. Enter the dishock, or heart fail Immediate Cause (Final disease or condition resulting in death)			ine In	toxi			, such as care	diac or respiratory	arrest,		Approximate Interval Between Onset and Death
Examin	miner	Sequentially list condition if any, leading to immed cause. Enter Underlying Cause (Disease or injury	ons, liate	Due to (or as	a conseque	nce of):	<del>-</del> ·				· · · · · · · · · · · · · · · · · · ·		
38760, ioate be executed physician and it the burial-transit	EX	that initiated events resulting in death) Last		Due to (or as	a conseque	nce of):							
O. Box 6 he deeth certili the attending	Physician/Medical	IF FEMALE: 23b. Was decedent predin the past 12 moni 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ths?	3c. If yes, outcome 1∐Live birth 4∏Pregnant a 9☐ Unknown	2 Fetal de	eath 3	□Ectopic pr □ Other (sp					23d. Date of de Month	elivery Day Year
rds, P., quires that the en signed by	Ď	Part II. Other significant	t conditions con	ntributing to death b	out not resulti	ing in the	underlying c	ause give	n in Part I.		tobacco		to the cause of death?
II RECOLI The law requise hes been pege 2 should	Completed									24a. Wa auto peri V2 Yes	opsy formed?	prior to death?	utopsy findings available completion of cause of s 2 No
of Vital Physician: T this certificat	To Be	25. Was case referred to examiner? 1 ☑ Yes 2 ☐ No	_	lospital: 1 ☐ Inpatie	ent 2 EF	VOutpatie	ont 3[\$}DC	Othe	-	Death (Check only	one)	6 ∏Other (Soi	ecify)
E 29 2 2	Ë	2 Accident	Pending investigation Could not be	28a. Date of Inju (Month, Da 5/22/04	ry ry Year) 28 4 5	8b. Time Injury :18	of 2	8c. Injury Work 1   Y		28d. Describe Unknov	how inj V11	jury occurred	
DIVISION Epitel or Attendit ours eller death. neral Director: At		4 🗍 Homicide	determined	28e. Place of Injudicing, et HOITE	c. (Specify)				a date and cl	Mechani	icsv	ille, Mo	
To the Hospitel c Within 24 hours et To the Funeral D completely filled is	Medical	(Check only 2区 one) 29b. Signature and title	Medical Exami	ner: On the basis of and manner st	<ul> <li>examination</li> </ul>	n and/or i	nvastigation,	in my opi	nion, death o	ccurred at the time	, date a	nd place, and du late signed (Mon	e to the cause(s) th, Day, Year)
		30. Name and address of	me	mpleted cause of d	ell (Item 2	PW 3a) (Type	Print)	001				ey 23, 20	
	State	HAMPO 31. Date filed (Month, Da		SDR45 32/ Registr	ar's Signatur	· ·	) )	rr Pe	enn Str	eet, Bal	time	ore, Mar	yland 21201

	State of Maryland / Department of Health and Mental Hygiene  1- For State Registrar  Certificate of Death  Reg. No. 11 2 11 5 2
	1. Decedent's Name (First, Middle, Last)  2. Date of Death 3. Time of Death
Physician /Medical	Bonnie Lee McLaughlin June 27, 2004 Year 11:25 P.M
Examiner	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death
7	Gilchrist Center for Hospice Care Towson Baltimore  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year   If Under 24 Hrs.   8 Date of Birth 9. Birthdays (State of Foreign
Funeral	219 26 9525 1 M 2 X F CL V(S Months Days Hours Min. (Month, Day, Year) Country)
ON B	Usual Residence of Decedent
2, 2, 2, 2, 2, 2, 2, 2, 2, 2, 2, 2, 2, 2	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
Ihe M	Maryland Baltimore Baltimore 1 □ Yes 2 ☒ No  10e. Street and Number 10f. Zin Code 10g. Citizen of What Country?
E G-24-C 11:24  S  uter death with the Maryland after must be rediffed at  first must be rediffed at  Funeral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?  6920 Donachie Road 21239 United States
death	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian,
or the	1 Never Married 2 Married 1 Nes 2 K No
O030 hours a board at Even	3 Wildowed 4 ADivorced Year or Dates:
BONNIE 21215-0036 ed within 72 hours afte get within "natural", or li no, the Medical Examinal, the Medical Examinal.	15. Decedent's Education (Specify only highest grade completed) [Give kind of work done during most of working life. DO NDT use retired)  16b. Kind of Business/Industry
212 212 d with	Elementary/Secondary (0-12) College (1-4or 5+)  12
ind be file tal Hy d oth	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame)
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Mar Mar d2 sh th and 7 Is m traum	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Ramona L. McLaughlin  1203 Meadowlark Drive, Towson, MD 21286
G Te, Te, Heal Heal	20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Incation - City of Town State
Pages ent of your ry or r	1 Burial 2 Cremation 3 Removal from State  '4 Donation 5 Other (Specify)  Bayview Crematory June 28, 2004  Baltimore, Maryland
Baltimore, Maryland 21215-0036  Baltimore, Maryland 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Highen. Importent: If item 27 is marked other than "natural", or items 23a or 28e-1 show any Injury or other traumatic event, the Medical Examinar must be rediffed at once.  To Be Completed by Funeral Director	21. Signature of Funeral Service Licensee Brian T. Chisholm Funeral Services of Dulaney Valley, P.A.
Na gagaga	200 E. Padonia Road, Timonium, MD 21093
2	23a Faut Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between
Physician /Medical	Immediate Cause (Final disease or condition resulting in death)  a. Small cell Lung Cancer months
Examiner	Due to (or as a consequence of):
le le le le le le le le le le le le le l	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury
8760, cate be executed obysician and the burial-transit dical Examiner	that initiated events
8760, ate be executed hysician and the burial-transi	resulting in death) Last  Due to (or as a consequence of):
P.O. Box 68760, not the death certificate be every by the attending physician etached for use as the burian Physician/Medical E	d
P.O. Box 6 that the death certific ed by the attending p detached for use as	IF FEMALE: 23b. Was decodent argument 23c. If yes, outcome of pregnancy
Box death cert s attendin d for use	in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy  1 Ves 2 No.
P.O.	9 Unknown 9 Unknown
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?
cord w require been si should t	Yes 2 No 3 Probably 4 Unknown
al Record The law requir	24a. Was an autopsy findings available prior to completion of cause of
Vital Recsicien: The law	performed? death?  1 Yes 2 No 1 Yes 2 No
of Vita Physician: This certificate director.	25. Was case referred to medical examiner?  1   Yes   2000
g Physer this neral control of T	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred
sior endin path. or: Af	2 Accident investigation M 1 Yes 2 No
Division of Vital Records, tal or Attending Physician: The law requires the stater death.  Is after death.  In py the funeral director, page 2 should be certification; To Be Completed by	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
pital cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a cours a	29a. Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the cause(a) and more and place.
Division of Vita To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, Medical Certification; To Be C	29a. Certifier (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check on
To th within To th comp	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)
	My brothy lily, und D25205 June 28,2005
V	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  11) A. Riley GBMC 6701 N-Charles St. Balto. Md 21305
State	W. A. Riley GBMC 6701 N-Charles St. Balto Md 21305  31. Date filed (Month, Day, Year) 32, Registrar's Signature
Registrar	JUN 2 9 2004 Show & Souls

nysician Medical		For State Registrar  1. Decedent's Name (First, Midd		State of		-	rtificate			III IV	2. Date of De	Reg. No.	004	2045
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neral	5	5. Social Security Number	6. Sex	7	. Age (In yrs. Ia	st birthday)	If Under Months	1 Year	If Under 2	24 Hrs. Min.	8. Date of Bir (Month, Da			place (State or Fore
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the burial-transit and property of the burial-transit and least Examiner		disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Last and initiated events resulting in death) Last	Б. с. d.	Due to (or	r as a conseque	nnce of):				3-				
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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Physician 940 AM 2004 Lynn A. McMaster /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTO SINAI HOSPITAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 ☐ M 2 💢 F Yrs Director 216-09-2211 Jan. 9 1937 MD 67 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Item 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, the Medical Examinational De notified at Yes 2 □ No Director MD n/a <u>Baltimore</u> 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4669 Falls Rd. 21209 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ ★ o If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify. ρ Specify: white 3 Widowed 4 Divorced McMaster, Lynn 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. OO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if Item 27 is marked other than " College (1-4or 5+) Elementary/Secondary (0-12) n/a n/a n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph Bernard McMaster Vivian Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly McCarty/niece 500 Sherwood Rd., Cockeysville, MD 21030 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 6/29/04 20c. Location - City or Town, State X☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State Dulaney Valley Memorial Gardens Timonium, MD 21093 22. Name and Address of Facility Lemmon Funeral Home of Dula 10 W. Padonia Rd., Timonium, 21. Igrature J Fur eral S-Ivven License Dulaney Valley, ium, MD 21093 Bryan W. Clary 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition neumonia 6 day resulting in death) /Medical Due to (or as a consequence of): Examiner -Une lumor Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a con-Examiner as the burial-transit been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 🗆 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an e autopsy performe 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 1 🗌 Yes 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manne of Death 28d. Describe how injury occurred After t Certification: 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Division of Vital Records,

To the Hospital or Attending Physician: filled in by the funeral director, hours after death within 24 hours a To the Funeral C

> State Registrar

31. Date filed (Month, Day, Year) IN 2. 9. 2004

29b. Signature and title of certifier

29a. Certifier

MD

29c. License number Kes

29d. Date signed (Month, Day, Year)

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

32. Registrar's Signature

Sinai

DHMH 17 Rev 1/2001

Registrar

JUN 2 9 2004

			1 - For State Registrar			JI IVIQI	ryland / Dep Co	ertificat				nerilai M	Reg. No.	004	20456
	Physic		1. Decedent's Na Christ		le, Last) berg					2. Date o			Death Day 25, 20	3. Time of Death 11:05 a ^M	
el.	/Medi Exami			(If not institution	n, give street and n ad	umber)		4b. City,	Town, o	r Location			4c. Co	ounty of De	ath
	Funeral Director		5. Social Security		6. Sex 1 ☐ M 2 <b>X</b> F	7. Age	(In yrs. last birthda) 63 Yrs.	) If Under Months	r 1 Year Days	If Under Hours		8. Date of B		9. Bi	rthplace (State or Foreigr Jountry) weden
	D		Usual Residence	of Decedent			10c. City, Town or I	anatin-				Mai 2	.1, 194	1 3	
	Maryla	to	MD		imore		Towson	.ocation							10d. Inside City Limits 1 ☐ Yes 2 MNo
	with the	Funeral Director	10e. Street and N					10f. Zip					10g. Citizer	of What C	Country?
	ms 23	nerai	11. Marital Status	ton Roa	12. Was De		er in U.S. 13	Was Dece	286 dent of H	ispanic Ori	igin? (Sp	ecify Yes or N	Swed		encan Indian,
000	be filed within 72 hours after death with the Maryland tal Hygiene. d other than *natural', or items 23a or 28a-1 show event, the Modical Examiner must be modified at	by Fur		rried 2 ☐ Mari	If Vac G	2 No		If Yes, spe	city Cuba	Specify:	n, Puerto	Rican, etc.)		Black, Wh	ite, etc.
0000-617	n 72 ho natur	leted	(Sp	15. Deceden	it's Education st grade completed	"	(Giv	edent's Usua e kind of wo	rk done	during mos	t of work	in <i>g</i>		of Business	s/Industry
717	filed withir Hygiene. ther than	Completed by	Elementary/Sec	condary (0-12)		(1-4or 5+)	Nurs	<i>00 NOT u</i> : Se	se retired	1)		•	Heal	th Ca	re
	8 a b 8	Be	17. Father's Name Gosta	(First, Middle, Nyberg	Last)							First, Middle		mame)	
mai yiaiin	2 should be and Menta Is marked aumatic ev	ြင	19a. Informant's	1 3	hip (Type, Print)		19b. Mai	ina Address	/Street	Ebba and Numbe		lljenbe al Route Numi		num State	Zin Code)
, MIC	2 6 2 6		Ms. Mar	ian Cor	ndon/Frie	nd						Lmore,			Zip Gode)
bannore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tone.			Cremation	3 Removal from	State	20b. Place of Disp cemetery, cre	matory or o	ther plac		1	Date Jun 28			Town, State
	mit. P. partme sortant / injury		* 4 ☐ Donation 21. Signature of F	5 □ Other (S uneral Service		44.0	Chesape					2004 eral Al		sville	e, MD
٥	9 9 E 8 8		156	= He	complications that			8/1/	Gree	en Pa	stur	es Dri	ze Bal	tives Ltimo:	re, MD
î	icate be executed bhysicien and she burial-transit	ical Examiner	Sequentially list of cause. Enter Unc Cause (Disease of that intiated even resulting in death	onditions,	b. 4 c. C	rtell	consequence of):  consequence of):  consequence of):	ert	(-s) (-s)	hla	ila	<u>a</u> (			
S 402 :0:	death certif e attending d for use as	Physician/Medical	IF FEMALE: 23b. Was decede in the past 1: 1 ☐ Yes 2 9 ☐ Unknow	2 months?		birth 2 [ nant at tim	Fetal death 3	Ectopic pro					23d.	Date of de Month	rivery Day Year
200	w requires that the base of signed by should be detact	ρλ	Part II. Other sign	icant condition	ditions contributing to death but at resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the caus			the cause of death?
	. The law requires that the sate has been signed by the page 2 should be detache	Completed	[Malnutration									24a. Was		b. Were au prior to death?	utopsy findings available completion of cause of
	s certification	o Be	25. Was case reference examiner?	rred to medical	Hospital:	Inpatient	аП <u>гв</u> (о	2 7 00	Othe			(Check only o			
5 ;	nding Phy th. : After this s funeral c	$\vdash$	27. Manner of Dea		28a. Date (Mon		2 ER/Outpatien 28b. Time of Injury		Bc. Injury Work	at Nur	2	8d. Describe	dence 6 🗔		cify)
	after dea Director	Certification:	3 Suicide 4 Homicide	6 Could r determ	ined   28e. Place	e of Injury ing, etc. (.	- At home, farm, st Specify)	eet, factory,				8f. Location ( City or Tox	Street and Nu wn, State)	mber or Ru	ral Route Number,
:	To the Nospital or Attending Physician: The law within 24 hours after dath.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical C	29a. Certifier (Check only one)	1 Certifyin 2 Medicel I	g Physician: To the Exeminer: On the b and-man	e best of no pasis of ex	armiation and of in	occurred a	at the time in my op	e, date and inion, deatl	I place, a	nd due to the d at the time,	cause(s) and date and plac	manner as	stated. to the cause(s)
1	Vithin To the comp	Me	29b. Signature and	Min (S	Muin	nin	)	1	License )-Z0	number 637			29d. Date sig		,
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DHMH 17 Rev 1/2001

ajken Nordberg unpend item#23a-c.Part II,27.PER ME.G833,7/27/04eg
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 4-04175 State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.) 2. Date of Death 3. Time of Delath 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** Majken Nordberg 25 2004 10:06 June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore N/A Sinai Hospital | Months | Days | Hours | Min. | See | Month, Day, Year | Feb | 20, 19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 ☐ M 2 🗙 F 83 Yrs. Sweden 126-28-1871 **Director** Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 27 is marked other than "natural", or Itema 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 X No Directo Pikesville MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21208 United States 1004 Park Valley Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. within 72 hours after 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Grocer al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Butcher 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be is marked o Unknown Johanson Valberg Nielson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health Item 27 Mr. Stig Nordberg/Husband 1004 Park Valley Court, Pikesville, MD 21208 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Jun 28 Department of smy injury or once. * 4 □ Donation 5 □ Other (Specify) 2004 Beltsville, MD Chesapeake Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 98600W Cremation and Funeral Alternatives lay 8717 Green Pastures Drive Baltimore, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Sepsis **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Peritonitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed Complications following a perforated Diverticulum burial-transi Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) 4☐ Pregnant at time of death P.O. cate has been signed by the pege 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 4 Unknown Emphsema; Atherosclerotic Cardiovascular Disease; Goiter; 1 🗌 Yes Completed End Stage Renal Disease 24b. Were autopsy findings available prior to completion of cause of death?

Yes 2□ No 24a. Was an autopsy performed? 2 No 1 Yes the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 □ No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification; To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral D completely filled in Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature 2 June 26, 2004 O.C.M.E. 30. Name and ad of death (Inem 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year) UN 2 9 2004

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32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year 4:26 PM Physician NasiaTka Rose lune 2004 /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Columbia Hospital General Howard County If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Days Hours 1 ☐ M 25 F 187-26-6864 74 Yrs. 1929 Pennsylvania Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28a-f show ust be notified at 1 ☐ Yes 2 No Jessup Director Howard Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20794 United States 7705 Washington Boulevard Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? th and Menial Hygiene. 17 is marked other than "natural", or items traumatic event, the Madical Examine Lin ☐Yes 2 No 1 Never Married 2 Married White 1 ☐ Yes 2X No Specify: Maryland 21215-0036 If Yes, Give Year or Dates: 3 Nidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Tavern & Motel Business Owner 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Joanne Camacci Angelo Aliucci 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jessup, Maryland 20794 7705 Washington Blvd. Stanley J. Nasiatka - Son t of Health other Baltimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 0 permit. Page Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 6/28/04 Elkridge, Maryland Meadowridge Mem. Pk. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Gary I. Kaufman Funeral Home At MMP., Inc. 7250 Washington Blvd. Elkridge, Maryland 21075 Ms 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Brain meningiona Physician months resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760, Physician/Medical as the IF FEMALE If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 0 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Munknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? 2 No 2 No 1 Yes certificate 1 Yes the Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 1 Inpatient 3 DOA Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) Injury at Work? 28d. Describe how injury occurred after death. 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours a To the Funeral I Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number title of certain 29b. Signature 3/19 D50338 30. Name and addre s of person who completed cause of death (Item 23a) (Type, Print) Parkway Columbia MD, Little PubleTe 11055 MOL. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 2 9 2004 Registrar

			1 - For State Registrar	State of	f Maryland		artment of rtificate o		nd Me	-	giene Reg. No	I	201.50	
			Decedent's Name (First, Middle, Last)								2. Date of Death Month June 18, 2004  3. Tim 6:17			
	Physici /Medio		Laura Omstead							June	18,	2004	6:17 AM M	
	Examir		4a. Facility Name (If not institution, gasta) 5411 Walther A		nber)		7.	, or Location of altimor			40	. County of Deat	h	
	Funeral Director		5. Social Security Number 6. 219-62-2262	Sex 1 ☐ M 2 🔀 F	7. Age ( <i>In yr</i> s. <i>la</i> 81	ast birthday) Yrs.	ff Under 1 Year Months Day		4 Hrs. 8. Min. Ja	Date of Bir (Month, Da an 3,	th 19. Year) 192	9. Birti Co Geo	hplace (State or Foreign untry) Orgia	
	pu »		Usual Residence of Decedent  10a. State 10b. County		10c City	. Town or Lo	cation						10d. Inside City Limits	
	ehov	5	Md 100. County	nore						1√2 Yes 2 □ No				
	28a-f	Director	10e. Street and Number			Darti	10f. Zip Code				10a. Cit	izen of What Co	11	
	3a or	ă	5411 Walther A	venue				1214				USA	,	
36	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or items 23e or 28e-1 ehow event, it e Medical Exactions frost be redified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	Armed For	2 <u>P</u> No e	1	Was Decedent of Yes, specify Co	ıban, Mexican,	in? (Specif Puerto Ric	y Yes or No an, etc.)	-	14. Race - Ame Black, White Specify: Wh	e, etc.	
00	hour turat	ed b	15. Decedent's I	Year or Da	ites:	16a. Dece	dent's Usual Occ	upation			16b. K	ind of Business/		
Maryland 21215-0036	in na	Completed	(Specify only highest g	rade completed) College (1	-40r 5+)	(Give life.	kind of work dor DO NOT use reti	ne during most ( red)	of working				and and and and and and and and and and	
212	d with giene. er ther	mo.		ınk	-401 04)	toba	acco pio	ker						
nd	be filed tal Hygie d other	Be	17. Father's Name (First, Middle, Las Herbert					18. Mother				Sumame)		
yla	should be and Mental is marked of aumatic even	2								lo11ar				
Jar	ie m		19a. Informant's Name/Relationship Charlotte Patti		0.22		ng Address <i>(Stre</i> Tyler B					or Town, State, 2 30549	tip Code)	
	Pages 1 and 2 should nent of Health and Mer int: if item 27 ie marke iry or other traumatic		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	☐Removal from S	20b. Pla Ce	ace of Dispo	sition (Name of natory or other p	T	Date	-		ocation - City or	Town, State	
Baltimore,	permit, Pages Department of Important: If It any injury or once.		*4 □Donation 5 NOther (Special Service Lice Fonal C.S.	11	ite   Megtor	St.	.Name and Add	lress of Facility	ard 6	55 W.	Ba1	timore	Street	
	00 % 4 Q		xville 1	Mill	e de de de de de de de de de de de de de	ва	Itimore	, MD Z	1201					
	Physician /Medical		23a. Pert1. Enter the disease, of cos shock, ar heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	a. Myc	curding.	Infa	ection	ying, such as G	ardiac or re	spiratory a			Approximate Interval Between Onset and Death	
1	Examiner	Jer	Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (	or as a consequ	enca ofj.			-					
0,	icate be executed physician and sthe burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (	or as a consequ	ence of):								
8760,	ate by hysic the bu	d												
.O. Box 6	The law requires that the death certificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live bi	come of pregnar inh 2 Fetal ant at time of de	death 3	Ectopic pregnar Other (specify)	ncy				23d. Date of deli Month	very Day Year	
Ω.	quires that t n signed by ild be deta	by	Part II. Other significant conditions	contributing to de	ath but not resu	lting in the ur	nderlying cause	given in Part I.			obacco u res 21		the cause of death?	
Vital Records,	The law requir ate has been si page 2 should l	Completed							_ [	24a. Was autop perio 1  Yes		prior to c death?	topsy findings available ompletion of cause of	
ital		0	25. Was case referred to medical					26. Place o	of Death (C	heck only o		12.00	20110	
of V	dils	To B	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 🗆 lr	npatient 2 🗆 E	R/Outpatren	t 3□ DOA C	Other: 4 🗆 Nurs	ing Home	5 Resid	dence (	6 □Other (Spec	ufy)	
ion o			27. Manner of Death  1 X Natural 5 ☐ Pending 2 ☐ Accident investigate	on	of Injury h, Day Year)	28b. Time of Injury	28c. In W	ury at fork? ☐ Yes 2 ☐ No		. Describe t	now infur	y occurred		
Division	taf or Attend s after death al Diractor; v ed in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	4 288. Place	of Injury - At hor ng, etc. (Specify)	me, farm, str	eet, factory, offic	е	28f.	Location (5 City or Tox			ral Route Number,	
	To the Hospital or Attending within 24 hours after death.  To the Funaral Diractor: Afte completely filled in by the fune	edical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as 2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due and manner stated.								and manner as place, and due	stated. to the cause(s)		
	To the To the Comp	Ž	29b. Signature and title of certifier	3	^			nse number			29d. Dat	e signed (Month	, Day, Year)	
			30. Name and address of person who	completed cause	e of death (ftem	23a) (Type.	D310				-3.0	. 22, 20	400	
			Carlawof Cosent 31. Date filed (Month, Day, Year) JUN 2 9 20	hall MD	3414 Gegistrar's Signatur	St. Par	UI S1, B	altima	ore n	ND T	212	18		
	Sta Registi		JUN 2 9 20	04 Sea	in to	Spa	Es.							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** June 23, Dorothy Mae Peters 2004 3:36P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Chapel Hill Nursing Home Sykesville Carrol1 Co. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 13 F Yrs. 87 Director 216-05-1541 March 8,1917 Ohio Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "netural", or itams 23a or 28e-f show the Medical Examinar must be notified at 1 ☐ Yes 2 X No Director Maryland Frederick Mount Airy 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 21771 107 Sunset Avenue United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 20 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White þ 3 € Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 10 YEARS Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be s 1 and 2 should be fir f Health and Mental H Item 27 is marked ott Harry Polen Adolphine LaMott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Gary Peters / Son 107 Sunset Avenue Mt. Airy, Maryland 21771 pernit. Pages 1 and Department of Health Importent: if Item 27 any Injury or other tr once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State 6/26/2004 1 4 □Dopation 5 □ Other (Specify) Oak Lawn Cemetery Baltimore, Maryland 21. Signature of Buneral Service Cicense 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part. Enter the disease, or complications that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner ng physician and as the burial-transit the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence o Physician/Medical IF FEMALE: USB 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy atten jo in the past 12 months? Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 certificate 2 No 1 Yes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Denth 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation hours after death. the 6 Could not be determined within 24 hours after dea To the Funerei Director completely filled in by th 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie TUNE 25-2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FURNACE BRANCH Rd GLGN BURNIE AD 21060 7445 M.D 37 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Maryland 21215-0036

Baltimore,

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Division of Vital Records,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Dav Year Stanley Pasda 26, June 2004 7:50 AMM /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Casey House Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) Days 1∭M 2□F 210-18-7969 Yrs 77 **Director** March 25,1927 Pennsylvania Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits event, the Medical Examiner must be notified at Maryland Montgomery 1 ☐ Yes 2 🕅 No Directo Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 18821 Sparkling Water Dr. or Items 23e #104 20874 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filled within 72 hours after c Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "naturel, or Item any injury or other traumatic event, the Mental and pince. 1 Never Married 2 X Married 1 XYes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Insurance Adjuster Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Stanley Pasda 2 (Unavailable) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Pasda / Wife 18821 Sparkling Water Dr.#104; Germantown, MD 20874 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) June Date 28 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2004 Beltsville, MD 21. Signature of Funeral Service Dicensee

Rapp Funeral and Cremation Service Facility Rapp Funeral and Cremation Service Facility Rapp Funeral and Cremation Service Facility Rapp Funeral and Cremation Service Facility Rapp Funeral and Cremation Service Facility Rapp Funeral and Cremation Service Facility Rapp Funeral and Cremation Service Facility Rapp Funeral and Cremation Service Facility Rapp Funeral and Cremation Service Facility Rapp Funeral and Cremation Service Facility Rapp Funeral and Cremation Service Facility Rapp Funeral and Cremation Service Facility Rapp Funeral and Cremation Service Facility Rapp Funeral and Cremation Service Facility Rapp Funeral and Cremation Service Facility Rapp Funeral and Cremation Service Facility Rapp Funeral and Cremation Service Facility Rapp Funeral and Cremation Service Facility Rapp Funeral and Cremation Service Facility Rapp Funeral and Cremation Service Facility Rapp Funeral and Cremation Service Facility Rapp Funeral Service Facility Rapp Funeral Service Facility Rapp Funeral Service Facility Rapp Funeral Service Facility Rapp Funeral Service Facility Rapp Funeral Service Facility Rapp Funeral Service Facility Rapp Funeral Service Facility Rapp Funeral Service Facility Rapp Funeral Service Facility Rapp Funeral Service Facility Rapp Funeral Service Facility Rapp Funeral Service Facility Rapp Funeral Service Facility Rapp Funeral Service Facility Rapp Funeral Service Facility Rapp Funeral Service Facility Rapp Funeral Service Facility Rapp Funeral Service Facility Rapp Funeral Service Facility Rapp Funeral Service Facility Rapp Funeral Service Facility Rapp Funeral Service Facility Rapp Funeral Service Facility Rapp Funeral Service Facility Rapp Funeral Service Facility Rapp Funeral Service Facility Rapp Funeral Service Facility Rapp Funeral Service Facility Rapp Funeral Service Facility Rapp Funeral Service Facility Rapp Funeral Service Facility Facility Facility Facility Facility Facility Facility Facility Facility Facility Facility Facility Facility Facility Fa 22. Name and Address of Facility Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 20910 Approximate Intervat Between Onset and Death Immediate Cause (Final **Physician** Metastatic Carcinoma disease or condition resulting in death) 10 months /Medical Due to (or as a consequence of): Examiner Lung Cancer 18 months Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner requires that the death certificate be executed that initiated events resulting in death) Last attending physician a for use as the burial-Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) s been signed by the s Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Prostate Cancer Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Hypercholesterolemia 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has page 2 Hypertension 1 Tes 2 💢 No To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice 1 ☐ Yes 2 X No Certification; To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending after death.

Director: Aff investigation 2 Accident 1 Tyes 2 🗌 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide hin 24 hours a the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 09470 June 26, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eugene P. Libre M.D.; 10400 Connecticut Ave., Kensington, MD 20895 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Maryland / Department of Health and M	0001
_			Certificate of Death	Reg. No. 2 3. Time of Death
	Physici	an	1. Decedent's Name (First, Middle, Last)	Month Day Year
	/Medic	al	Anakew Peakson	cation of Death 4c. County of Death
£	Examin	er	Remain	1.4.
	Funeral		Millennium Health Erehals Cexter Baltimor 5. Social Security Number 6. Sex 7. Age (In yrs. Jast birthday) If Under 1 Year It Under 24 Hrs.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
	Director		219-50-3136 12 M 20 F 56 Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) TAN, X 1, 1948 MARILLAND
	p ,		Usual Residence of Decedent	10d. Inside City Limits
	anylar show	_	10a. State 10b. County 10c. City, Town or Location	1. Mayes 2 □ No
	he M	ecto	MARYLAND N/A BALTIMORE  10e. Street end Number 10f. Zip Code	10g. Citizen of What Country?
	with	ᡖ	3310 WEST NORTH AVE. 31214	, ,
	72 hours after death with the Maryland netural', or Items 23a or 28a-f show fical Examiner must be notified at	Funeral Director	11. Marital Status  12. Was Decedent Ever in U,S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Sperif Yes, specify Cuban, Mexican, Puerto F	ority Yes or No- 14. Race - American Indian,
0	after or iter	필	Armed Forces? If Yes, specify Cuban, Mexican, Puerto F	
5-0020	ours a	þ	If Yes, Give 1 ☐ Yes 2 ☒ No Specify:  3 ☐ Widowed 4 ☒ Divorced Year or Dates:	Specify: BLACK
	72 h	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working)	16b. Kind of Business/Industry
121	within iene. than "r	ם	Elementary/Secondary (0-12) College (1-4or 5+)  CONSTRUCTION (JOSE	EKER CONSTRUCTION CO.
d 21	filed v Hygie other t	ပ္သ	1/ THGRADE CONSTRUCTION WORL  17. Father's Name (First, Middle, Last)  18. Mother's Name	(First, Middle, Maiden Surname)
an	ould be filed with Mental Hygiene. arked other than atic event, I've M	То Ве		RET ELIZABETH BROWN
Maryland	should nd Men marke umatic	۲	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural	
ž	and 2 salth a n 27 is		DAVID MATTHEW JONES (BROTHER) 3402 LUNCHESTER,	RD. BALTO. MO. 21215
ore,	of He item		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20a. Method of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or Town, State
Ĕ	Pages nent of I ant: If ite ury or o		4 Donation 5 Other (Specify) GARRISON FOREST CEME, 6	-2809 OWINGS MILLS, MD.
Baltimore	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "netural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility	WAJR. FUNERAL HOME
Ш	20 5 2 2	0	2140 N, FULTON A	VE., LOALTIMORE, MA. 21211
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	r respiratory arrest, Approximate Interval Between
7	Physician		Immediate Cause /Final	Onset and Death
	/Medical Examiner		resulting in death)	DISEASE
		P P	Due to (or as e consequence of):  1 1 PERTENSION	
	uted d ansit	Examiner	Sequentially list conditions  b. Due to (or as a consequence of):	
o,	The law requires that the death certificate be executed ete has been signed by the attending physician and page 2 should be deteched for use as the buriel-transit	EX	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initial edges of the cause (Disease or injury that initial edges of the cause (Disease or injury that initial edges of the cause (Disease or injury that initial edges of the cause (Disease or injury that initial edges of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause	
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P.O.	he de r the c	Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobecco use contribute to the ceuse of death?
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rds	v requires that the death certif been signed by the attending should be deteched for use a:	by by		24a. Was an autopsy performed? 24b. Were autopsy findings available prior to
00	w red s bee	Set C	DI ABETISMECLITY	performed? available prior to completion of cause of death?
æ	he la te ha: age 2	Completed		1 Yes 2 No 1 Yes 2 No
ita	en: 7	Bec	25. Was case referred to medical 26. Place of Death	(Check only one)
of Vital Records,	nysici nis ce I direc	10		ne 5 ☐ Residence 6 ☐ Other (Specify)
פ	ng Pl		1 Natural 5 Pending (Month, Day Year) Injury Work?	8d. Describe how injury occurred
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Division	or Attending efter death. Director: After in by the fune	Certification:	3 Suicide 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town, State)
_	pours ours merel filled	S E	29a. Certifier Tertifying Physician: To the best of my knowledge, death occurred at the time, date end place, at	nd due to the cause(s) and manner as steted.
	e Hos 24 h e Fur	edlcal	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.	
	To the Hospital or Attanding Physicien: The law within 24 hours efter death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	ž	29b. Simature and the of certifier 29c. License number	29d. Date signed (Month, Pay, Year)
			D24100	6/25/04
	VX/		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Diace An Maria
_	·1			YPLACE BAL, MD21201
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. AMEND ITEM 20B PER FH, 6832,06/29/04DHB Reg. No 2 0 0 4 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Year **Physician** POLES 07:45 AM AGNES June 2004 /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Fecility Neme (If not institution, give street and number, Examiner Sinai Hospital of Baltimore Baltimore City If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day) 7. Age (In yrs, last birthday)

Syrs. Birthplece (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** Days Months 1 M 2 K F 202-03-439 Director Usual Residence of Decedent 10d. Inside City Limits 10a. Stete 10b. County 10c. City, Town or Locetion 1 X Yes 2 □ No Funeral Directo MARVLAND 10e. Street end Number 10g. Citizen of What Country? AWAY AVENUE USA. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status I ☐ Yes 22€ No If Yes, Give Year or Detes: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ BLACK 3 ☐ Widowed 4 Divorced Be Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) DEPT. OF SOCIAL SERVICE VISOR 2++GRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) HENRY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Nam elationship (Type, Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) YNDA (DAUGHTER Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State WOODLAWN, MA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Feality 21. Signature of Funeral Service Licensee TR, FUNERAL HOME which N. 2140 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Acute myocardial inforction 1 day disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the ceuse of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☒ Unknown 1 Yes 2 No Alzheimer's disease δ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed 2 MNo 1 ☐ Yes 2 No t 🗆 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 SInpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 22 No Certification: To 3□ DOA 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

attending physician end for use es the burial-transit Division of Vital Records, P.O. Box 68760 filled in by the funeral director After this Director: within 24 hours after of To the Funeral Director Completely filled in by the Hospital

2121

Baltimore,

50

29a. Certifier

29b. Signature and title of certifier annia maciantine, DO

12 Certifying Physicien: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29c. License number 29d. Date signed (Month, Day, Year)

RES CO

2004 June 23

30. Name and address of "arson who completed cause of death (Item 23a) (Type, Print)

Sinai Hospital of Baltimore Ann T. MacIntyre, DO

31. Date filed (Month, Day, Year)

(Check only one)

32. Registrer's Signeture

JUN 2 9 2004

**DHMH 16 Rev 6/95** 

edical

State Registrar

State of Maryland / Department of Health and Me	ental Hygiene
1 - State Registrar Certificate of Death	Reg. No. 2001 20464
1. Decedant 3 (42/10 (1 mot), Easty	2. Date of Death Month Day Year 3. Time of Death
Physician /Medical JOHN AMBROSE POWERS JR.	JUNE 20 2004 5:45 P M
Examiner  4e. Fecility Name (If not institution, give street and number)  MARINER HEALTH OF FOREST HILL  FOREST HILL	4c. County of Death HARFORD
5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	B. Date of Birth 9. Birthplace (State or Foreign
Director 2/6-14-8284 15M 2 F 8/ Yrs. Months Days Hours Min.	(Month, Day, Year) Country)
Usuat Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
10a. State 10b. County 10c. City, Town or Location	1 ☐ Yes 2 No
The state of the state and Number 106. Street and Number 106. Zip Code	10g. Citizen of What Country?
21014	(1.SA
11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married  1 Never Married	ify Yes or No- ican, etc.)  14. Race - American Indian, Black, White, etc.
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10a. State 10b. County 10c. City, Town or Location    County	16b. Kind of Business/Industry
15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  Salls Mall	5 6 10 0
The secondary (6-12) College (1-3015+)  Sales Man  18. Mother's Name  18. Mother's Name	Salls
17. Father's Name (First, Middle, Last)	First, Middle, Maiden Sumame)
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19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wile  19c. Mary Powers — Wi	BED ALE MD 21014
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1 SkBurial 2 Cremation 3 Removal from State Cemetery, crematory or other place)	4 TIMONIUM MD
20a. Method of Disposition  1 Staurial 2 Cremation 3 Removal from State  1 Donation 5 Other (Specify)  21. Signatur, of Funeral Service Licens  22. Name and Address of Facility	INS FUNIFAL Chapel
1 Contract D Newport DE P	respiratory arrest. Approximate
23a-Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	Interval Between Onset and Death
Physician disease or condition resulting in death)  Physician Medical Medical Due to (or as a consequence of):	
Examiner Seal Steel of Campails	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	
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	1 Yes 2 No 1 Yes 2 No
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25. Was case referred to medical examiner?  1	d. Describe how injury occurred
2 Accident investigation  2 Accident investigation  3 Suicide 6 Could not be  28 Place of Injury - At home farm street, factory office	14 Location (Canada and Mumbaras Dural Davida Numbara
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	nd due to the cause(s) and manner as stated.
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	29d. Date signed (Month, Day, Year)
David 5 Din D32215	June 21, 2004
X	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	21014
	21014

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day, **Physician** Month MILLIAM KANDALL, 0 /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Deeth Aton manor BALTIMORE NA 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 12M 2DF 72 Director Usuel Residence of Decedent 10a, State 10b. County 10c. City, Town or Location iges 1 and 2 should be filed within 72 hours atter death with the Marylar it of Health and Mental Hygiene.

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1 ☐ Yes 2 1 No autopsy Division of Vital 1□ Yes 2. No director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this funeral ( 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After or Attending 1 XNatural 5 Pending within 24 tours after death. To the Funerel Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide Hoapita 1 Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 9 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (T ..., Print) Blud TO COTON 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JUN 2 9 2004

**ORIGINAL** 

JIII'AM RANDA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Stata Registrar 1-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death @OldAge (In yrs. last birthday) Date of Birth **Funeral** 1 M 2 F Months Days Director Usuel Residence of Decedent 10a. State 10c. City, Town or Location r than "neturel", or Items 23a or 28a-f show the Medical Executar must be notified at 10d. Inside City Limits 1 ☐Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 11. Marital Status Was Decedent E Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 □ Yes 2 D No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No 3 ☑ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. PO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4er 5+) ondary (0-12) Homemaken 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle artment of Health and Mental ortant: If item 27 is marked o Iorris Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) or other 20b. Place of Disposition cemetery, crematory 20a. Method of Disposition 20c. Location - City 1 Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner Due to (or as a consequence of): for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Yes Yes 2 🗆 No 3 Probably 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2000 1 Yes To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and tifle of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

TAHOORA

32. Registrar's Signatur

KAWAJA

eled cause of death (Item 23a) (Type, Print)

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Sported

rossroad

			1- For State of Maryland / Dep	eartment of Health and Mertificate of Death	lental Hygie	2001	201.67
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physic /Medi		Thomas Lester Rider		June 27	Day Year , 2004	7:00 P M
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	7.00 1
			2611 Gray Manor Terrace	Dunda1k		Balti	more
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Ye	9. Birthpl	lace (State or Foreign try)
	Director		172-34-3499 1X□M 2□F 63 Yrs.	World Days Todis Will.	Dec. 31,		nsylvania
	and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L	acation		1/	Od. Inside City Limits
	Manyl f ehc	ō					1 ☐ Yes 2 ☑ No
	the t	rect	Maryland Baltimore	Dundall 10f. Zip Code		Citizen of What Count	
	3a or		2611 Gray Manor Terrace	21222	Tog.	United St	•
	death ms 2:	Funeral Director	•		ecify Yes or No-	14. Race - America	
9	after or ita	Fur	1 □ Never Married 25€ Married   1 □ Yes 2 5€ No	Was Decedent of Hispanic Origin? (Spell Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, e	
03	72 hours after death with the Maryland natural', or itams 23a or 28a-f ehow dical Examine must be confibed at	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: W	hite
21215-0036	be filed within 72 hours after death with the Marylan hal Hygiene. ad othar than "natural", or itams 23a or 28a-f ehow avent, the Madical Expresse must be conflict at	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Giv.	edent's Usual Occupation of work done during most of worki	16b	. Kind of Business/Ind	ustry
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anc	ould be fi Mental H arkad ot atic aver	Be	17. Father's Name (First, Middle, Last)		(First, Middle, Maid	-	
Ĕ	2 should be and Mental is markad raumatic av	10	Jacob L. Rider, Jr.		lis Mae B		
Maryland		1		ing Address <i>(Str</i> eet a <i>nd Number or Rur</i> a 1 Gray Manor Terra		y <i>or Town, State, Zip (</i> lk, Mary1a)	
	s 1 and 2 if Health itam 27 i		20a. Method of Disposition 20b. Place of Disp	-		Location - City or Tov	
Baltimore,	of of		1 Burial 2 Cremation 3 Removal from State	matory or other place) Wn Cemetery 7/1/200			
			Littompment			Baltimore,	
ä	permit. Departr imports any inj			2. Name and Address of Facility uda-Ruck Funeral Ho			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en	22 Wise Ave. Dung ter the mode of dving, such as cardiac of	lalk, Mary r respiratory arrest.		2.2 Approximate
	Physician		Immediate Cause (Final	Renal can	_	1	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)  a. Due to (or as a consequence of):	THEIRU CON			LUCOUT
	Examiner						
		Jer	Sequentially list conditions, if any, leading to thin charte cause. Enter Underlying Cause (Disease or injury				
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Ö,	ate be executed hysician and the burial-transit		resulting in death) Last Due to (or as a consequence of):				
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9	death certifica e attending ph d for use as t	Mec	IF FEMALE:				
Box	ath cuttend	lan/	23b. Was decedent pregnant in the past 12 months?	Ectopic pregnancy		23d. Date of delivery	
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٥	The law requires that the di ste has been signed by the page 2 should be detached		Part II. Other significant conditions contributing to death but not resulting in the u	nderhing cause gwan in Part I	23e Did tobacc	use contribute to the	aguag of death?
ds,	signed be del	d by		noonying caase given are are.		A .	oly 4 Unknown
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of	Phy r this	. To	1 Inpatient 2 EH/Outpatien	IL 3 DOX 4 INUISING HOI	ne 5 k esidence 8d. Describe how in	6 ☐Other (Specify)	
O	th. : Afte	tior	27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  2 Accident investigation 28a. Date of Injury (Month, Day Year)  28b. Time of Injury (Month, Day Year)	f 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No		ary occurred	
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Ö	al or A s after il Dirac	Certification:	4 Homicide building, etc. (Specify)		City or Town, Sta	te)	
	ospit hours inara ly fille		29a. Certifying Physician: To the best of my knowledge, deat	occurred at the time, date and place, a	nd due to the cause	s) and manner as state	ed.
	To the Hospitel or Attending Ph within 24 hours after death. To the Funaral Director: After th completely filled in by the funeral	edical	(Check only one)  2 Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurre	d at the time, date a	nd place, and due to th	ne cause(s)
	To t with To t	≥	29b. Signature and title of certifier	29c. License number	29d. D	ate signed (Month, Da	ny, Year)
	N		Madhu Wand	N 14140	0 10	NE 2803	2004
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, MADHU CHAUDHRY, 6569 N CMC	Print She ot Bo	Urnas	MDD	204
				(1167 01100)			
	Sta		31. Date liled (Month, Day, Year) 32. Registrar's Signature	y ,			

			_ For	ase Type or State o	of Marylar	nd / Depa	artmen	t of H	ealth a		-		egible.	
			1 - State Registrar			Ce	rtificat	e of L	Death			Reg. No.	106	20468
	Physic	ian	Decedent's Name (First, Midd	fle, Last)							2. Date of De Month	Day	Year	3. Time of Death
1	/Medi	cal	Cynthia Tucker Ross								June	23	2004	6:02 P M
	Examir	ner	4a. Facility Name (If not institution		umber)				Location of	of Death			ounty of Death	
	Funeral		Gilchrist Hos  5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under	TOWS	If Under:	24 Hrs.	8. Date of Bir			place (State or Foreign
	Funeral Director		220-90-0108 Usual Residence of Decedent	1□M 2 <b>½</b> PF	4	Vro	Months	Days	Hours	Min.	(Month, Da	ay, Year)	Col	intry) cyland
	yland		10a. State 10b. Count	у	10c. Cit	ty, Town or Lo	ocation		•					10d. Inside City Limits
	e-f-e	ctor	Maryland Howa	ard		Elkrid	ge							1 ☐ Yes 2 ☑ No
	ith the	Directo	10e. Street and Number				10f. Zip	Code				10g. Citizer	of What Cou	untry?
	ath w		6121 Hunt Club	Road			2	1075				Unit	ed Sta	ites
Maryland 21215-0036	72 hours after death with the Maryland natural', or itema 23a or 28e-f ehow dical Examinational be publiced	by Funeral	11. Marital Status  1 □ Never Married 2[X]Ma  3 □ Widowed 4 □ Divorce	rried 1 ☐ Yes	<b>2∕∑</b> No ive		Was Deced If Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)		Race - Amer Black, White pecify: Wh	
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no	Pages nent of I ant: if it		1 ☐ Burial 2√√Cremation 4 ☐ Donation 5 ☐ Other (	3 Removal from	State	cemetery, crei	matory or o	ther place						
Baltimore,	그는 분들		21. Signature of Funeral Service		bal	t. Wasi	II. CE 2. Name an			-	9/04	Laure	el, Mar	ryland
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0 0	ng Ph fter th meral		27. Manner of Death  Natural 5 ☐ Pendi	28a. Date (Mor	of Injury oth, Day Year)	28b. Time of Injury	2	8c. Injury Work	at ?		28d. Describe I			
<u>S</u> i	death. ctor: A	catic	2 Accident invest	igation			М		es 2□N	No				
Division of Vital Records,	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deterr	mined 288. Place	e of Injury - At he ling, etc. (Specif	ome, farm, str y)	eet, factory	, office		2	28f. Location (5 City or Tov		umber or Rura	al Route Number,
	To the Hospital or A within 24 hours after To the Funerel Directorpletely filled in by	edicai	29a. Certifier 1 Certifyi (Check only 2 Medical	ng Physician: To th I Examiner: On the t and mar	e best of my kno basis of examina nner stated.	wledge, death tion and/or in	occurred a	at the time in my op	e, date and inion, deat	d place, a h occurre	and due to the ed at the time,	cause(s) and date and pla	manner as s ce, and due to	stated. the cause(s)
	To the To the Comp	ž	29b. Signature and title of certific	er /			29c	. License	number		1	,	gned (Month,	
}			ATT COL	Com	0				8300			SUN	e 23	2004
	10		30. Name and address of person	who completed cau	se of death (Item	23а) (Туре,	Print)	c /fi	-B-1	14.	neM	0 00	0.	
	-		31. Date filed (Month, Day, Year	Thes wil	Ponietraria Cia	1110	VEKK	J 0 F	100/	1600	NEW VV	r colld	VX.	
	Sta Registi				Registrar's Signa									
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				*		ORIGINA	\L	*						

June 23, 2004 at loi Oapm

Ross, Cynthia &

			1 - For Stata Registrar		State of	Marylar				lealth a			Rag. I		-	2046	9
	Physici /Medic		1. Decedent's Name (First,  Ryan Danie									2. Date of D Month June	24,	2004	'ear	3. Time of Dea	
7	Examin		4a. Facility Name (If not ins	-				1		Location of	of Death			4c. County of			
			6620 Washii						ridge r 1 Year	e If Under	24 Hrs	0. Data of F	Lindle	Howard		10	
	Funeral Director		5. Social Security Number 219-55-5287		M 2□F	4	last birthday) Yrs.	Months		Hours	Min.	8. Date of B (Month, I SEP • 2	рау, Үөг 4 ,	hool -	Cour	lace (State or Fo try) Land	reign
	and		Usual Residence of Deced 10a. State 10b. 0			10c. Ci	ity, Town or Lo	cation	<del></del>						1	0d. Inside City L	imits
	Many in shi	tor	MD Hov	vard			Elkric	đae								1 ☐ Yes 🛠	XNo
	h the	Director	10e. Street and Number					<del></del>	p Code				10g. (	Citizen of Wh	at Coun	try?	
	23a c	alD	6620 Washii	ngton I	31vd., 1	Lot 34		2	1075					USA			
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene. It it item 27 is marked other then "natural", or Items 23a or 28e-f show or other treumatic event, the Madical Examinating the nufficed at	by Funeral	11. Marital Status 1 XNever Married 2[ 3 ☐ Widowed 4 ☐ Dir		12. Was Deced Armed Ford 1 ☐ Yes 2 If Yes, Give Year or Dat	es? No		Was Dece If Yes, spe 1 ☐ Yes		ispanic Ori in, Mexicar Specify:		acity Yes or N Rican, etc.)	10-	14. Race - Black, Specify:	Americ White, Whi	etc.	
Š	2 hou			cedent's Edu			16a. Dece	dent's Usu	al Occup	ation during mos	t of work	ina	16b.	Kind of Busi	ness/Ind	dustry	
21215-0036	within 7 ene. then "r	Completed	(Specify only Elementary/Secondary (		College (1-	4or 5+)	life.	DO NOT I	ise retired	)	( OF WORK	ng .					
	e filed within al Hygiene. I other then 'vent, I've Ma		0	fields ( and)			ch:	ıld		10 Marks	ada Nasa	(Fine Adia)	in Admire	child			
and	uld be fil fental H rked ott tic even	Be	17. Father's Name (First, M		D-4	Too						(First, Midd					
3	2 should be and Mental ris marked creumatic even	10	Raymond Fi			, Jr.	19b Maili	na Addres	s (Street			ynn Su al Route Num			ate Zin	Code)	
Maryland	d 2 sl th an th an 17 Is r		Tammy Lynn		, , ,	icon/m						Blvd.,					
	Health tem 27 I		20a. Method of Disposition		all rergi	20b.	Place of Dispo	sition (Na	me of			Dit vu.,		Location - Ci			
OE	ages ent of tr. If i		1 ☐ Burial 2 X Crem 1 ☐ Donation 5 ☐ O			tate	ttimore	-			5/27/	<b>'</b> 04		Laurel	, MI	)	
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral S			C	Ga	ry L.	Kau	ss of Facilit Éman	<b>Éune</b> :	ral Ho	me @	Meadow	rido	e MP, Ind	c <b>.</b>
			23a. Part1. Enter the	ase, or compl	ications that ca	used the dea	th. Do not ent	$50~W_{\odot}$	ashir de of dyin	gton g, such as	Blvc cardiac	r respiratory	arrest,	ge, MD	_2]	075 Approximate	
	Physician		shock, or heart failure Immediate Cause (Final	a. List only o			. / . A									Onset and Deat	
	/Medical		disease or condition resulting in death)	-		r as a consec										1 week	
	Examiner		Sequentially list conditions		PRO	GRESS	SIVE S	SKEL	ETAL	DEF	FORM	1 ITY				4 years	5
	D ==	ner	Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or injury		Due to (o	r as a consec	quence of):					1				4 years	
	cate be executed oblysician and the burial-transit	Examiner	that initiated events resulting in death) Last	1	J	SYND,										tyears	
8760,	cian a		, , , , , , , , , , , , , , , , , , , ,		Due 10 (0	i as a consec	querice or;.										
387	physi physi s the t	dlcal		-	d												
.O. Box 6	ne death certifica the attending ph hed for use as th	Physiclan/Med	IF FEMALE:  23b. Was decedent pregn in the past 12 months 1 □ Yes 2 □ No 9 □ Unknown	ATTL		th 2□Feta nt at time of c	al death 3[	⊒Ectopic p ⊒ Other (s						23d. Date of Month		ry Day Year	
۳.	that the deed by the detached		Part II. Other significant c	onditions co	ntributing to dea	ath but not res	sulting in the u	nderlying	cause giv	en in Part I.		23e. Dio	tobacc	o use contrib	ute to th	e cause of death	1?
ds,	w requires that been signed t should be det	d by										1 🗆	] Yes	2 No 3	☐ Prob	ably 4 ⊟Unkr	nown
Vital Records	law req as beer 2 shou	ompleted										24a. Wa	s an			osy findings avai	
Re	9 4 9	mo					-					aut per 1 ☐ Yes	opsy formed? 2 <b>Z</b>	prio dea	ith?	npletion of cause 2□ No	) Of
ta	ician: Th certificate rector, pag	e C	25. Was case referred to r	nedical						26. Place	of Death	(Check only				20110	
	N S D	To B	examiner? 1 ☐ Yes 2 No	ŀ	Hospital: 1 🗆 In	patient 2	] ER/Outpatier	nt 3 🗆 D	OA Oth	er: 4 □ Nu	ırsing Ho	me 5 Re	sidence	6 Other	(Specify	)	
n of	Jing Ph J. After th funeral		27. Manner of Death	Pending	28a. Date of (Month	Injury , Day Year)	28b. Time o Injury	f	28c. Injun Worl	/ at k?		28d. Describe	how in	jury occurred			
Division	or Attending after death. Director: After in by the fune	Certification:	2 Accident 3 Suicide 6	investigation Could not be determined	28e. Place	of Injury - At h	nome, farm, sti	M reet, facto		Yes 2		28f. Location	(Street	and Number	o <i>r Rur</i> a	Route Number,	
Ö	s after	Cert	4  Homicide		pulldin	g, etc. (Speci	iry)					City or T	own, Sta	ite)			
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	edical (	29a. Certifier 1 C (Check only 2 M	ertifying Phy edical Exemi	sician: To the to ner: On the bas and manne	sis of examina	owledge, deat ation and/or in	h occurred vestigation	at the tin	ne, date an pinion, dea	d place, th occurr	and due to the	e cause e, date a	(s) and mann nd place, and	er as st	ated. the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of	certifie				29	c. Licens	e number			29d. [	Date signed (	Month, I	Dey, Year)	
	0	7	> hance	galut	tinny			1	5311	002			Ju	JE 25	,20	04	
	17		30. Name and address of p														
	~		NANCY HUT		1D P	ARK 38	1; 50 H	NS H	PKIN	'S Hos	PITA	LIBAL	Tim	ORE, MA	TRYL	ANDZ12	87
	Sta Registr		31. Date filed (Month, Day		32. Re	gistrar's Sign	Sture A	racks	7								

			1 - For State Registrar	State of Ma	rylar	•	artment rtificate			ind M	•	giene Reg. No.		20670
	Physici	an	1. Decedent's Name (First, Middle, L Serena	ast)		Robins	son				2. Date of De. Month	ath Day	2004	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, g 124 W. Franklin		pt.	1305	4b. City, To			f Death	6	4c. C	ounty of Death	12:45pm M
	Funeral Director		5. Social Security Number 6. 214-20-6199 Usual Residence of Decedent	Sex 1		last birthday) Yrs.	It Under 1 Months [	Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bird (Month, Da 2-28-	h y, Year) -27	9. Birth Cou <b>M</b> d	place (State or Foreign intry)
	Maryland f show led at	tor	10a. State 10b. County  Md. NA	1	10c. Cit	ty, Town or Lo	cation cimore							10d. Inside City Limits 1 X Yes 2 □ No
	h with the 3a or 28a st be notif	Funeral Director	10e. Street and Number 124 W. Franklir	Street Apt	. 1	305	10f. Zip C	ode 2120	01			10g. Citize	on of What Cou	intry?
980	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. If Health and Mental Hygiene. Itiam 27 is marked other then "natural", or Itams 23a or 23a-f show other traumatic event. If is Modical Exactinational Locational Location at the modical Exactination and the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the c	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:		1	Was Deceder f Yes, specify		spanic Orig n, Mexican Specify:	in? (Spe , Puerto i	ecify Yes or No Rican, etc.)	1	Race - Amer Black, White pecify: B	
Maryland 21215-0036	I within 72 ho jiana. r than "natu	Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12) 8th grade	Education trade completed) College (1-4or 5-	+)	(Give	dent's Usual C kind of work DO NOT use nestic	Occupa done di retired)	tion uring most	of workii	ng		of Business/Ir	ples Home
land ;	ould be filed Mental Hygi arkad othar atic evant, II	To Be C	17. Father's Name (First, Middle, Las Charles		)uee	n				's Name Anni	(First, Middle,	Maiden Si	Moore	
, Mary	1 and 2 should. Health and Men tem 27 is marka		19a. Informant's Name/Relationship Rosetta Code	(Type, Print) Daughter	:						Route Number timore,		Town, State, Zi 21207	p Code)
Baltimore,	Pages 1 a nent of Hea ant: If itam ary or otha		20a. Method of Disposition  1		0	Place of Dispo cemetery, crer ing Mei	natory`or othe	of er place	6	-29 <u>-</u>	oate O4		ition - City or T allstow	
Balt	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Lio	7 Fees	×	>	Name and March	F.H	East		1101 E.	Nort	ce, Md. ch Ave.	21202
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or to shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	aDue to or as a	it	h. Do not ent	er the mode o	bot dying hov	such as o	cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death
8760,	death certificate be executed ettending physician and of for use as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c. Due to (or as a d.										
0	the death certific y the attending p ched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at the g ☐ Unknown	Feta	ldeath 3□	Ectopic preg Other (spec					230	d. Date of deliv Month	ery Day Year
rds, P	Se UD O	by	Part II. Other significant conditions	contributing to death bu	t not res	ulting in the u	nderlying cau	se givei	n in Part I.			bacco use 'es 2 🗀 I	\	he cause of death? pably 4 □Unknown
Vital Records,	has b	ompleted					·				24a. Was autop		prior to co death?	opsy findings available impletion of cause of
Vital	Physician: The this certificate ral director, page	BeC	25. Was case referred to medical examiner?	Hospital:		- ""					(Check only o	ne)		
ot	ding Phys h. After this funeral di	tion: To	1 Yes 2 No  27. Manner of Death Natural 5 Pending 2 Accident investigati	28a. Date of Injury (Month, Day	,	28b. Time of Injury		Other	at	2	ne 5 X Resid		Other (Special	(ý)
Division	al or Attanding after death. I Diractor: Afte d in by the fune	ertification;	3 Suicide 6 Could not determine	be One Place of Injur	ry - At ho (Specif	ome, farm, str y)	eet, factory, o	office		2	28t. Location (S City or Tow	treet and f m, State)	Number or Rura	al Route Number,
	To the Hospital or At within 24 hours after of To the Funaral Diract completely filled in by	edical C	29a. Certifier (Check only one)  1 Certifying I	Physician: To the best of aminer: On the basis of and manner state	examina	wledge, death	n occurred at restigation, in	the time my opi	e, date and nion, death	place, a	and due to the dead at the time, d	cause(s) ar	nd manner as s ace, and due to	tated. the cause(s)
)	Tott within Tott comp	Me	29b. Signature and title of certifier	Chon M	0			1 -	number	5/	'	1	signed (Month,	
	7		30. Name and address of person who	o completed cause of de	ath (Item	n 23a) (Type,	Print) PAUL TE	ACE	E #40	9	BAU	IMOR	5 MD	212 <b>6</b> 2
	Sta Registr		31. Date till Month, gay 20074	32. Registra	Signa	CHINAS C								

		Please	Type or Prin	nt in Bl	ack in	delible Ink	. Ensure A	II Copie	s Are	Legible	e.	
		For State	State of Ma	aryland			lealth and I	Mental Hy	/gien	9		
		1 State Registrar	- 4)		Ce	rtificate of	Death		Reg. No	2001	1 2	047
Physic		Decedent's Name (First, Middle, La     Frank	Marshall		D.	nrmon d		2. Date of D Month	Da		ar	Time of Death
/Med Exami		4a. Fecility Name (If not institution, giv		<u></u> -	N	4b. City, Town, o	or Location of Death	June	23,	2004 County of D		2:22 a ^M
X		Gilchrist Cer	ter			Tows	on			Balti	more	
Funeral		5. Social Security Number 6. S	Sex 7. Ag	e (In yrs. las		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of B	irth ay, Year,	9.	Birthplace Country)	(State or Foreign
Director		Usual Residence of Decedent	X	89	Yrs.			March	2,	1915 R	hode	Island
IL Z 12.15-UU30 filed within 72 hours after death with the Maryland Hygiene. the riban "natural", or Itama 23a or 28a-1 show ont, the Madical Examinar must be notified at	1.	10a. State 10b. County		10c. City,	Town or L	ocation					10d. lr	nside City Limits
88-1-8	Director	Maryland Baltin	ore		T:	imonium			,		1	☐Yes 2MNo
with the	P	10e. Street and Number				10f. Zip Code			10g. Ci	tizen of What	Country?	
eath na 23	Funeral	7 Glenamoy Road,	unit 201	Ever in U.S.	13		1093	pecify Yes or N	0.	USA 14. Race - A	merican In	ndian
after o		1 Never Married 2 Married	Armed Forces?				Hispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)			/hite, etc.	orari,
hours a	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1□Yes 21XNo	Specify:			Specify:	Whit	:e
natu	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of work	king		ind of Busine		
withir iene. than	дша	Elementary/Secondary (0-12)	College (1-4or 5	i+) (		s Invest	*			ocial : Iminis:		-
Hygi other	0	17. Father's Name (First, Middle, Last,					18. Mother's Nam	ne (First, Middle			LIALI	оп
yiair ould be Mental harkad o	To B	Frank H.	Raymo	ond			Grace		Woa	rbuto	n	
ore, Mary dattice Z.I.Z.13-0030 Is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Itam 27 is marked other than "natural", or Itama 23a or 28a-1 show other traumetic event, the Modical Examiner must be multified at		19a. Informant's Name/Relationship (	Турө, Print)		19b. Maili	ng Address (Street	and Number or Ru	ral Route Numb	er, City	or Town, Stat	e, Zip Code	э)
c, N l and lealth im 27 her tr		Mike Raymond/Gra	ndson	20h Bloc		E. Bidd1	e St., Ba	ltimore				
Pages nent of h		20a. Method of Disposition  1 XBurial 2 Cremation 3		cem	netery, cre	matory or other pla	^{сө)} Јune	28, 20	04	ocation - City		
Dattillor permit. Pages Department of Important: if if any injury or o		* 4 □ Donation 5 □ Other (Specifical Services 121. Signature of Funeral Services 122.	_	Dula	2:	2. Name and Addre	m. Grdns.			monium		
Dearth Departh Imports any inju		Bryan W. Clar	Leise	-		Lemmon F	uneral Ho donia Roa	me of I	ular	ey Val	lley	Inc.
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death.	Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory	arrest,	I, PID	App	roximate rval Between
Physician		Immediate Cause Final	and a	st-t		und: II	emtirle	can	PRA	1	Ons	et and Death
/Medical Examiner		disease or condition resulting in death)	Due to (or as	a consequer	nce of): U	ncerta	in pro	m ory s	site	6		and a
Examine	_	Sequentially list conditions, if any, leading to immediate	b. Due to force									
ted nsit	nine	Cause (Disease or injury	Due to (or as	a consequer	nce or):							
be executed iclan and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequer	nce of):							
The law requires that the death certificate be executed the law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	=		d									
w requires that the death certificate been signed by the attending physic should be detached for use as the behalf	Physiclan/Medica	IF FEMALE:										
ath cer	lan/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth	2 Fetal de	eath 3[	Ectopic pregnancy	,			23d. Date of Month	delivery Day	Year
the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of deat	th 5[	Other (specify) _				Wild Har	Day	1021
that the detail		Part II. Other significant conditions of	ontributing to death be	ut not resulti	ng in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco t	use contribute	to the cau	use of death?
requires leen signe	ed by							10	Yes 2	<b>2</b> No 3□	Probably	4 Unknown
aw re	plet							24a. Was		24b. Were	autopsy fir	ndings available
The I	Completed								psy ormed? 2 No	prior death	?	ion of cause of
cian: cian: ertific actor.	Be (	25. Was case referred to medical examiner?					26. Place of Deal				,	1
Physic this of ral direction	-T	1 Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatie		VOutpatier		4   Nursing H				pecify)	pospide
ding h. After funer	tlon	Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	Year)	Bb. Time of Injury	Wor	yar k? Yes 2 □ No	28d. Describe	now injur	y occurred		
Attan r deal actor	ertification:	3 Suicide 6 Could not b	e 28e. Place of Inju	ary - At home	e, farm, str	eet, factory, office		28f. Location (			Rural Rou	te Number,
s afte	Cert	4   Homicide	building, etc	с. (Бресіту)				City or To	wn, State	)		
To the Hospital or Attanding Physician: The law within 24 hours after death.  To the Funeral Diractor: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier  (Check only 2 Medical Exam	ysicien: To the best oniner: On the basis of	of my knowle	edge, death	occurred at the tir	ne, date and place,	and due to the	cause(s)	and manner	as stated.	nauco(s)
the h	Medi	0.107	and manner sta	ted.								
S M S S		29b. Signature and title of certifier	1) <0		m	29c. Licens	CAAT			e signed (Mo		•
21	1	30. Name and address of person who	completed cause of di	ath (Item 20	3a) (Type	Print)						
10		W.A. Rilay	UG Brace	167	101 /	V. Chu	les St.	Ball	to n	121	206	
	ate	31. Date filed (Month, Day, Year)	32. Registra	ır's Signatur		Ta P						
Regist	rar	HIN 2 9 2004	Senera	4	1	soul						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Year Margaret Ruff 24 June 2004 /Medical 10:10P 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Future Care Cherrywood Nursing Care Reisterstown <u>Baltimore</u> If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖫 F Days Director 217-05-4961 87 Aug 4, Maryland Usuat Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ?7 is marked other than "neturel", or Items 23a or 28a-f show treumetic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland Baltimore Reisterstown 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11212 Thompson Ave 21136 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status ☐Yes 2X No f Yes, Give 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) Machinist Koppers Co. permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other eny injury or other treumaric areas 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jessie Warner Ruff Mary Elizabeth Sullivan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Ruff (Son) 11212 Thompson Avenue Reisterstown, MD 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Other (Specify) Good Shepherd Cemetery 6-30-2004 Ellicott City, Maryland 4 Donation ^{22. Name and Address of Facility}
Witzke Funeral Home of Catonsville, Inc.
1630 Edmondson Ave Catonsville, Maryland 21228 21. Signatur Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MYOCARION INFARETION /Medical Due to (or as a consequence of): Examiner CORONARY Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a sunsaguence or): attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed DECUBITUS of Vital 1 Yes 2 No 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ۵ 1 ☐ Yes 2 No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After To the Hospitel or Attending Division 1 Natural 2 Accident Injury 5 Pending death, 1 ☐ Yes 2 ☐ No investigation I Director: d in by the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number h 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MIGUEL SADOVNIK. 1838 GREENE TREE Rd, BALTIMEE, MDZIZW

State Registrar

31. Date filed (Month, Day, Year)



			. For	State of Mary		artment of H		-	jiene	
			1 - For State Registrar		Cei	rtificate of	Death	R	eg. No UU	4 20473
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month		3. Time of Death
5	/Medic		Elva Miriam Resau					1	24 200	
	Examin	er	4a. Facility Name (If not institution, give s			1	r Location of Death	1	4c. County of	
	<b>5</b>		Keswick Multi-Care 5. Social Security Number 6. Sex		yrs. last birthday)	If Under 1 Year	re City If Under 24 Hrs.	8. Date of Birth		timore
	Funeral Director		216-03-3194	M 2₹1F 8		Months Days	Hours Min.	8. Date of Birth (Month, Day March 3	1,1919	Birthplace (State or Foreign Country)  Maryland
	pun *		Usual Residence of Decedent  10a. State 10b. County	100	c. City, Town or Lo	cation				10d. Inside City Limits
	Maryli f sho	ō	MD Anne Ai	1	Glen Bur					1 ☐ Yes 2√2 No
	the 728a-	Funeral Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wha	
	h with	alD	217 Ditty Court			2106	1		U.S.	Α.
	ems 2	ner	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of H	ispanic Origin? (Span, Mexican, Puerto	pecify Yes or No-	14. Race -	American Indian, White, etc.
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic evant, I'm Medical Exercitiver must be notified at once.	by Fu	1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give	1		Specify:	, , , , , , , , , , , , , , , , , , , ,	Specify:	white
Maryland 21215-0036	tural		15. Decedent's Educ	Year or Dates:	16a, Deced	dent's Usual Occup	ation		16b. Kind of Busin	
212	nin 72	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of work done o	during most of world)	king	100. (11.10 0) 500.	ioodiiiddoi; y
21	d will giene er the	Com	12		Secr	etary			Law Off:	ice
<u>n</u>	be filed tal Hygi d other evant, t	Be	17. Father's Name (First, Middle, Last)					ne (First, Middle, I		
yla	should ind Men imarke umatic	^L	Corbin N. Hammond	0.00	101 11 10			ta Steve		
Mai	d 2 st th and 7 Is n traun		19a. Informant's Name/Relationship (Tyr.  Mr. Vernon Resau /			Oug 1 Co				
	tam 27		20a. Method of Disposition		b. Place of Dispo	Quail Co sition (Name of		Date	9 Mary Lat 20c. Location - Cit	
Ë	Pages ent of nt: # i		1  Burial 2  Cremation 3  Re  1  Onetion 5  Other (Specify)	emoval from State	-	natory or other placed ge Mem.	June		Elkridge,	, MD
Baltimore,	permit. Pages Department of I Important: If its any injury or of		21. Signature of Prieral Service Licen			. Name and Addres				
<u> </u>	8 9 E 8 8		- Landrik	allas In	01364 1	Second A	venue S.V	W., Glen	Burnie,	MD 21061
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	Due to (or as a cor	PANCE of):	d Dev		or respiratory arre	est,	Approximate Interval Between Onset and Death
68760,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last	Due to (or as a cor						
P.O. Box 6	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as the	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pri 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3 □	Ectopic pregnancy Other (specify)			23d. Date of Month	f delivery Day Year
	es tha igned be det	by	Part II. Other significant conditions conf	1		nderlying cause give	en in Part I.			te to the cause of death?
ord	w requir been si should	eted	2 11	007	egse			1 ☐ Ye	s 2 No 3	Probably 4 Unknown
Vital Records,	The law cate has b page 2 s	Completed	Diabetes m	ellius				24a. Was ar autops perforn 1 ☐ Yes 2	y prior ged? deat	e autopsy findings available r to completion of cause of th? Yes 2 \sum No
Vita	ician certifi ector	Be	25. Was case referred to medical examiner?	ospital:		Othe		h (Check only one		
	To tha Hospitel or Attanding Physician: The I within 24 hours after death.  To tha Funaral Diractor: After this certificate ha completely filled in by the funeral director, page	tlon: To	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 28a. Date of Injury (Month, Day Yea	2 ER/Outpatien 28b. Time of Injury	28c. Injury Work	or: 4 Nursing Ho rat √? Yes 2 □ No	ome 5 🗋 Reside 28d. Describe ho		Specify)
Division of	Hospitel or Attanc     La hours after deatt     Funaral Diractor: etely filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (Sp.	At home, farm, streecify)			28f. Location (Str City or Town		r Rural Route Number,
	To tha Hospitel or within 24 hours afte To tha Funaral Dir completely filled in	edical C	29a. Certifier (Check only one) Certifying Physical Examin	ician: To the best of my er: On the basis of exar and manner stated.	knowledge, death mination and/or inv	occurred at the tim restigation, in my op	ne, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and manne ite and place, and	or as stated. due to the cause(s)
	To tha k within 24 To tha F complete	Me	29b. Signature and title of certifier	1-0		29c. License	number	29	d. Date signed (M	fonth, Day, Year)
			K/ Hother	Mily.	an	Da	2301		Tune 2	× 200×
	10		30. Name and address of person who con	mpleted caused death	(Item 23a) (Type, I	29c. License Do	St. Bal	fo md	2120	٥
	Sta Registr		31. Date filed (Month, Day, Year) JUN 2 9 2004	32. Registrar's S	ignature	parket				

			State of Maryland / Department of Health and Me Registrar  Certificate of Death	ental Hygie	ne
				Reg. 2. Date of Death	No. U 0 4 2 0 4 7 4
	Physici		JOSEPH RENSON RAY IR		Day 2 Year 4 255 AM
	/Medic Examin			V -	4c. County of Death
			North Arundel Hospital Glen Burnie		Anne Anundel
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min	8. Date of Birth (Month, Day, Ye	0 Righteless (Ctate or Courter
	Director		220-07-9878 123 M 2 F 87 Yrs. White Says 183 M 2 F 87	7-12-191	6 MARYLAND
	land ow		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	Mary -f sh	to	MD ANNE ARUNDEL GLEN BURNIE		1 ☐ Yes 2 🛣 No
	ith the Marylar or 28a-f show	Irec	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Country?
	ath with the Maryla 123a or 28a-f show	Funeral Director	6524 CLEAR DROP COURT 21060	U	.S.A.
	after death w or Items 23a	iner	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto R		14. Race - American Indian, Black, White, etc.
ဂ္ဂ	s afte	by Fu	1 □ Never Married 2 □ Married 1 □ Yes 2 🖄 No   1 □ Yes 2 🖔 No   1 □ Yes 2 🖔 No   Specify: Year or Dates:	, ,	Specify: WHITE
3-003p	within 72 hours after death with the Maryland ene. than "natural; or flems 23a or 28a-f show I.s. Moulcal Examiliar mat be motified at	ed b	3 Milliowed 4 Divorced Year or Dates:  15. Decedent's Education 16a. Decedent's Usual Occupation	16h	Kind of Business/Industry
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7	giene giene er tha	Completed	12 SELF EMPLOYED	FA	ARMING
yland	al Hy d oth	Be (	17. Father's Name (First, Middle, Last)	(First, Middle, Maid	den Sumame)
<u>X</u>	Ment Ment arke	ဥ	JUSEPH BENSON RAY, SR. LOLA HAWK	INS	
Z	permit. Pages 1 and 2 should be filed within 72 hours after des Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items any injury or other traumatic event, it a Montel Experiment once.		19a. Informant's Name/Relationship (Type, Print)  MRS • KAREN RIGER - DAUGHTER  19b. Mailing Address (Street and Number or Rural  1209 SCOTTS KNOLL CT		, , , , , , , , , , , , , , , , , , , ,
a) —	1 and Health em 2 thar		MRS. KAREN RIGER - DAUGHTER 1209 SCOTTS KNOLL CT.,  20a. Method of Disposition 20b. Place of Disposition (Name of Day		LE, MD 21093  Location - City or Town, State
	ages int of t: If It		2XX8urial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)		
Saitimor	artme ortan injury		*4 Denation 5 Other (Specify) MEADOWRIDGE 6/30/ 21. Signure of Fund Solving Lio piece 22. Name and Address of Facility STIM	Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Contro	KRIDGE, MD
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			27 a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or hock, or heart failure. List only one cause on each line.	respiratory arrest,	Approximate
	Physician		In midiate Cause (Final discuss or condition a Leute Renal Failure		Interval Between Onset and Death
	/Medical		resulting in death)  Due ty (or as a consequence of):		
	Examiner		Sequentially list conditions.  b. ASTHMA		
	ed sit	lne	Sequentially list conditions, if any, leading to immediate cause. Enter Unice lying Cause (Disease or injury		
	ding Physician: The law requires that the death certificate be executed. h. After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit	Examiner	that initiated events resulting in death) Last Due to (or as a consequence of):		
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Š	h cert endin	M/UE	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy		23d. Date of delivery
	e deal	sicla	in the past 12 months?  1 □ Yes 2 □ No  9 □ Unknown	<del></del>	Month Day Year
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ń	The law requires that the title has been signed by thoage 2 should be detache	þ	Part ii. Dither significant conditions contributing to death but not resulting in the underlying cause given in Part I.	1 Tes	o use contribute to the cause of death?  2 No 3 Probably 4 © Unknown
cords,	requ been should	etec		,0	
บั	has ge 2	Completed	•	24a. Was an autopsy performed;	24b. Were autopsy findings available prior to completion of cause of death?
NI G	ificate or, pa	e Co	or Maria to the first	1□ Yes 2☐1	
	Physician: r this certifica ral director,	0 8	examiner?		6 □Other (Specify)
5	ng Ph ter th	T:u	27. Man or of Death 1 Natural 5 Pending (Month, Day Year) 28b. Time of 28c. Injury at 28 Injury Work?	3d. Describe how in	
200	andir sath. or: Af he fu	atic	1 Natural 5 Pending (Month, Day real) Injury Work? 2 Accident Investigation M 1 Yes 2 No		
Ž	or Att	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	If. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
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	To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical	29a. Certiflier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and Check only one) 1 ☐ Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	d at the time, date a	(s) and manner as stated.  nd place, and due to the cause(s)
	ro th Mithin To th compl	Me	29b. Signature and title of certifier 29c. License number	29d. D	Date signed (Month, Day, Year)
			Menn C. WM 12 111 194136	Ju	ne 75, 2014
	6		30 Name and address of person who completed cause of death (Item 23a) (Type, Print)	61	ne 75', 2004 Burnie, MD. 21061
	<b></b>			, Blen	DUNNIE, ID. 20051
	Sta	te ar	31. Date filed (Month, Day, Year)  32. Registrar's Signature		

			1 - For State Registrar	State of Maryla		artment <i>rtificate</i>			, ,	jiene	<b>1</b> 1.	201.75
	Physic		Decedent's Name (First, Middle, Last,     MARCIA			RII	BIN		2. Date of Dea	th_	2004	3. Time of Death 3:51 A M
	/Medi Examir		4a. Facility Name (If not institution, give	street and number)				ation of Death	CONL	4c. County		J.31 A ***
	Francis		9030 ALLENSWOOD F 5. Social Security Number 6. Sec		. last birthday)	If Under 1		ANDALLS Inder 24 Hrs.	TOWN  B. Date of Birth	1		BALTIMORE
L	Funeral Director		218-40-6845	IN OUT	61 Yrs.			ours Min.	OCT. 5	1942	Cour	place (State or Foreign htry) MD
	yland		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	ocation					1	0d. Inside City Limits
	the Marylan 28a-f show notified at	ctor	MD BALT:	IMORE	RANDA	ALLSTO	WN					1 □ Yes 2 No
	3a or 2	by Funeral Director	10e. Street and Number 9030 ALLENSWOOD RO	ΠΑΠ		10f. Zip C		1133	1	0g. Citizen of		utry? J.S.A.
	tems 2	nera	11. Marital Status	12. Was Decedent Ever in L Armed Forces?	J.S. 13.	Was Deceder			ecify Yes or No- Rican, etc.)		e - Americ	an Indian,
980	within 72 hours after death with the Maryland ane. than "natural", or Items 23a or 28a-f show is Medical Exercite Frenchilled at	by Fu	1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐ Yes 2 💢 No If Yes, Give Year or Dates:		1□ Yes 20		ecify:		Specif		WHITE
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	ges 1 and 2 should be filed within 72 hours after death with the Maryla it of Health and Mental Hyglene. If Itam 27 is marked other than "natural", or items 23a or 28s-f show or other traumatic event, the Medical Exertificatings the routified at	Be	17. Father's Name (First, Middle, Last)  WILLIAM		POTAS	211			e (First, Middle, i	Maiden Suman		WICL ANDED
Maryland	should and Men a marka umatic	은	MILLIAI'I  19a. Informant's Name/Relationship (Ty	pe, Print)				EDITH Tumber or Rura	al Route Number	; City or Town,		AUSLANDER Code)
	ss 1 and 2 of Health a Itam 27 is r other trea		DAVID RUBIN / HUSE		9030	ALLEN:	SWOOD	ROAD -	RANDAL	LSTOWN,	MD 2	21133
mor	ages ent of h nt: If Its y or ot		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)	emoval from State	Place of Dispo cemetery, cren H EL ME	sition (Name matory or othe EMORIAI	er place)	1	/2004	20c. Location - DΛNDΛ		OWN, State
Baltimore,	permit. Pages Department of Important: If I any injury or one		21. Sign 1/17 Feral Service License	from the	22	. Name and	Address of F	acility SOL	LEVINS	ON & BR	OS.,	INC.
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the dea	89	900 RE	ISTERS	STOWN R	OAD - P	IKESVIL	LE, M	1D 21208 Approximate
Ų.	Physician	١,	Immediate Cause (Final disease or condition	2	emort	600	/ ^	anor		lan	7	Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as consec	quence of).				Ψ.	- 4	1	1
	P ≅	ner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	Due to (or as a consil	quence of):						-	
	ate be executed thy sician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	 Due to (or as a consec	quence of);						_	
8760,	cate be ex physician the buria	dical E			,							
x 68	eath certifica attending ph	/Med	IF FEMALE:	3c. If yes, outcome of pregn	ancv							
.O. Box	the thech	Physiclan/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live birth 2 Feta 4 Pregnant at time of c 9 Unknown	al death 3	Ectopic preg Other (speci				23d. Dat Mo	e of delive	ry Day Year
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Records,	aw require s been sig 2 should b	Completed		9					24a. Wasar	1 24b. V	Were autop	psy findings available
al Re	: The lav cate has	Com							autops perform 1 Yes 2	y ned?	rior to com leath?	npletion of cause of 2 □ No
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n of	ding Phy h. After thi funeral c	on: T	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		Injury at Work?		28d. Describe ho			
Division	r Attandi er death ractor: A by the fi	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At h	ome, farm, stre	M eet, factory, o	1 ☐ Yes :	-	28f. Location (Str	eet and Numbe	er or Rural	Route Number
Ö	Ital or after ral Dire	Certi	4   Hollicide	building, etc. (Special					City or Town	, State)		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funaral Director: After this certifica completely filled in by the funeral director.	Medical	29a. Certifier 1 💢 Certifying Phys (Check only 2 Medical Examination)	icien: To the best of my knower: On the basis of examination and manner stated.	owledge, death ation and/or inv	occurred at t restigation, in	the time, dat my opinion,	te and place, a death occurre	and due to the ca ad at the time, da	use(s) and ma te and place, a	nner as sta	ited. the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier	1 1	)	29c. L	icense numb	ber	29	d. Date signed	(Month, D	lay, Year)
	13		30. Name and address of person who co	molecular cause of death (Hear	m 23a) /Tune 1	(Print)	127	604	,	6/2	0/04	
	\			mpleted cause of death (liter 1838 Greene	Med	Rd.	Pelle	esulle	, Ma	12120	P	
	Sta Registr		31. Date filed (Month, Day, Year)  JUN 2 9 2004	32. Registrar's Signa	ature	park						

			For State Ragistrar	State of Maryla		artment of			iene	00176
			Decedent's Name (First, Middle, L.			inouto or		2. Date of Deat		3. Time of Death
	Physici /Medi		CHARLES	5 (	MON			06.24	2004 Yea	6:00 AM
	Examir		4a. Facility Name (If not institution, gr. 802 WALNUT I	ve street and number)		4b. City, Town, BALTIA	or Location of Deal		4c. County of D	eath
	Funeral Director			Sex 7. Age (In yr. 1	s. last birthday) Yrs.	If Under 1 Yea Months Days			Year 50 9.1	Birthplace (State or Foreign Country)
	ow ow		10a. State 10b. County	10c. (	City, Town or Lo	ocation				10d. Inside City Limits
	Many Fe sh	ţō	MD NI	A BA	MINO	RE				1 ∰KYes 2 □ No
	h the	Director	10e. Street and Number		•	10f. Zip Code		1	0g. Citizen of What	Country?
	23e c	a D	802 WALNUT A	VENUE		2122	29		USA	
	tems	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of If Yes, specify Cul	Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - A Black, W	merican Indian,
36	rs afte	by F	1 K Never Married 2 Married 3 Widowed 4 Divorced	1 ★Yes 2 No If Yes, Give Year or Dates:	i	1□Yes 2⊠No			Connifu	
21215-0036	within 72 hours after death with the Maryland ene. then "neturel; or Items 23e or 28e-f show to Mailcal Exc. interf. sast by motified at		15. Decedent's B		16a. Dece	dent's Usual Occu	upation		16b. Kind of Busine	LACK
215	hin 7.	plei	(Specify only highest gill Elementary/Secondary (0-12)	rade completed)  College (1-4or 5+)	(Give	kind of work done DO NOT use retire	e during most of wo ed)	rking	-	33 madatiy
21	filed wil Hygiene other the	Completed	12TH GRADE	NN	MILMA	ary off	FICER	F	EDERAL	GOVT.
pu	be fill d off	Be	17. Father's Name (First, Middle, Las	t)				me (First, Middle, A		
Maryland	2 should be filed withir and Mental Hygiene. Is marked other then eumatic event, ILe M.	2	JOSEPH SINON  19a. Informant's Name/Relationship	(Type Print)	10h Mailie	Add /C4		SINGLE		
Ma	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. item 27 Is marked other then "neturet", or Items 23e or 28e-f show other treumstic event, II'e M. cilcal Exx. iliter: 481 to inclined at		المستحسل	IKINS		PARR A		TO - MO	City or Town, State 21215	a, Zip Code)
ē,	ges 1 and t of Health If item 27 or other tr		20a. Method of Disposition	20b.	Place of Dispo	sition (Name of	*!		20c. Location - City	or Town, State
Ë	Pages nent of I int: If it		1 Surial 2 □ Cremation 3 in 4 □ Donation 5 □ Other (Spec	Removal from State	ARRISON	natory or other pla FORES	, ,	0.04	DWIMIGS	MIUS, NO
Baltimore,	permit. Pag Department Importent: any injury conce.		21. Signature of Funeral Service Lice		128				SERVICE	
	20 E # 9		Dang (	+	51	51 BALTO.	NATE PH	KE BALTI	b. MD 2	1229
40			23a. Part1. Enter the disease, or conshock, or heart failure. List only	one cause on each line.				or respiratory arre	st,	Approximate Interval Between Onset and Death
ì	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Myoca		intare	ction			Onset and Death
	Examiner		(	Due to (or as a conse	quence of):					
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underging Cause (Disease or injury	b. Due to (or as a conse	quence of):					-
	ocuted nd transi	Examine	that initiated events	C						d
90,	ate be executed hysician and the burial-transit	EX	resulting in death) Last	Due to (or as a conse	quence of):					
8760,	ate hy the	dical		d			_		=	
Вох 6	eath certific attending p for use as l	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr	nancy				Old Date of a	4.15
	death e atter	lciar	in the past 12 months?	1 Live birth 2 ☐ Fet 4 ☐ Pregnant at time of		Ectopic pregnand Other <i>(specify)</i> _	су		23d. Date of d Month	Day Year
P.0	at the de by the a	Physician/M	9 🗆 Unknown	9□ Unknown						
	res tha igned be del	by	Part II. Other significant conditions		sulting in the ur	nderlying cause gr	ven in Part I.			to the cause of death?
of Vital Records,	w requir been si should I	Completed		betes		C '1		1 🗆 Ye	s 2 No 3	Probably 4 Unknown
<b>3ec</b>	has by	mpl		igestive he		Tallune	-	24a. Was an autopsy	prior to	autopsy findings available completion of cause of
<u></u>		e Co	htn - hu 25. Was case referred to medical	1 pertension	_				No 1□Ye	
Ξ	Physician: this certific ral director,	o Be	examiner?  1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	TEP/Outpation	3 DOA Oti	26. Place of Dea her: 4 \(\sum \) Nursing H	th Check only one		
of	g Phy er this eral c	$\vdash$	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Inju	4 Livuising H	28d. Describe how	nce 6 Other (Sp v injury occurred	pecify)
Sior	Attending I r death. ector: After by the funer	atlo	1 Natural 5 Pending investigation	n	Injury		Yes 2 □No			
Division	el or Attendii s after death. el Director: A ed in by the fu	Certification:	3 Suicide 6 Could not to determined		nome, farm, stre	et, factory, office		28f. Location (Stre City or Town,	eet and Number or I State)	Rural Route Number,
	Hospitel or 24 hours afte Funerel Dir tely filled in I		29a. Certifier 1 Certifying P							1
	To the Hospitel or / within 24 hours after To the Funerel Dire completely filled in b	edical	(Check only one)	hysician: To the best of my kn miner: On the basis of examin and manner stated.	owledge, death ation and/or inv	estigation, in my	ime, date and place opinion, death occu	, and due to the car rred at the time, da	use(s) and manner a te and place, and du	as stated. ue to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licens	se number	29	d. Date signed (Mor	nth, Day, Year)
			> Abraron	Balanson	MD	000	55157		6/28/	104
	1		30. Name and address of person who	completed cause of death (Ite		Print)				
	\		SHA-RON D 31. Date filed (Month, Day, Year)	ALANSON  32. Registrar's Sign	ature	o N .	6-REEN	E 51.	Bultin	we MD
	Sta Registr		JUN 2 9 201	)4 Serva	B	Some.				21201

		,		partment of Health and Mental Hygiene ertificate of Death Reg. No. 1
	Physici		1. Decedent's Name (First, Middle, Last)  BEATRICE SHIELD.	2. Date of Death 8. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give street and number)  BON SECOUR HOSPITAL	4b. City, Town, or Location of Death  BALTIMORE  4c. County of Death  N/A
	Funeral Director		5. Social Security Number  6. Sex 1 M 2 F 7. Age (In yrs. last birthda)  1 M 2 F 84 Yrs.  Usual Residence of Decedent	If Under 1 Year   If Under 24 Hrs.   8. Date of Birth (Month, Day, Year)   9. Birthplace (State or Foreign Country)   Min.   OA - DA - DA - DA - DA - DA - DA - DA -
	Maryland -f show	tor	10a. State 10b. County 10c. City, Town or I	
	with the 3e or 28e	Funeral Director	10e. Street and Number 1649 N. PAYSON STREET	10f. Zip Code 10g. Citizen of What Country?
36	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Ptygiene. ortant: If item 27 is marked other than "netural", or items 23e or 28e-f show injury or other traumatic event, the Medical Exam and must be notified at ing.	by Funera		Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.  1 □ Yes 2 ► No Specify:  Specify: BLACK
21215-0036	within 72 hou ene. than "neture he Medical E	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	edent's Usual Occupation a kind of work done during most of working DO NOT use retired)  16b. Kind of Business/Industry
	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, the Ma	To Be Co	12TH GRADE N/A  17. Father's Name (First, Middle, Last)  CHIC BOOKE	18. Mother's Name (First, Middle, Maiden Surname) FIELDER BODZE
Maryland	nd 2 shou lith and M 27 is mar r traumat			ing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  N. PAYSON ST. BALTO. MD 21217
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.		20a Method of Disposition 20b. Place of Disp	osition (Name of Date 20c. Location - City or Town, State
Balti	permit. Pag Department Important: I any injury o		21 Circh tro of Europeal Consine Licensee	2. Name and Address of Facility AUGHN C. GREENE FUNERAL SERVICE 151 BALTO, NATL PIRE, BALTO, NO 21229
	Physician		23a. Part1. Entertibe disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	Approximate Inter the mode of dying, such as cardiac or respiratory arrest,  YOCATUA IN FARMOR Onset and Death
8760,	/Medical Examiner  ohysician and the purial-transit	dical Examiner	Sequentially list conditions of any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  CONGLETURE  Due to (or as a consequence of):  CONGLETURE  Due to (or as a consequence of):	Heart Failure
.O. Box 6	e death certific he attending p ed for use as	Physician/Med		□Ectopic pregnancy 23d. Date of delivery □ Other (specify) Month Day Year
٥.	iw requires that the s been signed by the should be detach	ed by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1   Yes 2   No 3   Probably 4   Unknown
Il Records,		Completed by		24a. Was an autopsy findings available autopsy performed?  1 □ Yes 2 No 1 □ Yes 2 No
f Vital	Physicien: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatie	26. Place of Death (Check only one)  nt 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)
ion of	Attending Ph r death. sctor: After th by the funeral		27. Manner of Death 1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation 28a. Date of Injury (Month, Day Year)	
Division	tal or Attors after de al Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, si building, etc. (Specify)	reet, factory, office  28f. Location (Street and Number or Rural Route Number, City or Town, State)
7	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	one) Medical Examiner: On the basis of examination and/or in	th occurred at the time, date and place, and due to the cause(s) and manner as stated.  Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
	To To Con	2	29b. Signature and title of certifier  Jerance Jambon. D	29d. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)
	0		30. Name and address of person who completed cause of death (Item 23a) (Type TERANCE LAMB M. D.	Bon Secous Hospital, Baltimore no
	Sta Registr		31. Date filed (Month, Day, Year)  32. Registrar's Signature	Ban Secous Hospital, Baltimore no

		-	State of Mary  1- State Registrar	land / Depa		lealth and M	lental Hygi	•	ole.	201.78
			negistrar  1. Decedent's Name (First, Middle, Last)		Timouto or		2. Date of Death			3. Time of Death
	Physicia		Brian L. Sullivan				June 23	, ^{Day} 2004	Year	6:25 PM M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	or Location of Death		4c County	of Death	0.23 111
	E Adillii	e.	Home; 3120 Keswick Road			Baltimore			N/A	
	Funeral		5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,	Vaarl		place (State or Foreign
	Director		212-62-5779 ¹X™ 2□ F	50 Yrs.	Months Days	Hours Min.	July 17	,1953		yland
	pu ,		Usual Residence of Decedent	City Town as L					1.	Od Incid- City Livia
	show	_		c. City, Town or Lo						0d. Inside City Limits  XXXXYes 2 □ No
	Ba-f	cto	Maryland N/A	ратт	imore					
	or 2	Dire	10e. Street and Number 3120 Keswick Road		10f. Zip Code	21211	10	g. Citizen of V	hat Coul US	•
	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f show the Madical Exartiral rusal by Indillind at	Funeral Director		i- 11.0	M D 4		ait. Van aa Na	14 Page		
	er de Itam	nue	11. Marital Status  12. Was Decedent Ever Armed Forces?	in U.S. 13.	If Yes, specify Cub	lispanic Origin? (Spe an, Mexican, Puerto	Rican, etc.)		k, White,	can Indian, etc.
36	rs aft	y F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No 1 ☐ Yes, Give Year or Dates:		1 ☐ Yes 21/21/No	Specify:		Specify	: w	hite
우	tura atura	Completed by	15. Decedent's Education	16a. Dece	dent's Usual Occup	pation	1	6b. Kind of Bu		
15	n "na Media	plet	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give	kind of work done DO NOT use retire	pation during most of worki d)	ng			
212	d with giene	E	12+		CAD Opera	ator		SF	RBR	
b	e file	Bec	17. Father's Name (First, Middle, Last)			18. Mother's Name			θ)	
<u>/ai</u>	uld b Venti	2	Robert Sullivan			Eve.	lyn Bost	on		
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylar It of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23s or 28s-1 show or other treumatic event, It is Medical Examinal institutional in or other treumatic event, It is Medical Examinal institutional.	ľ	19a. Informant's Name/Relationship (Type, Print)			and Number or Rura	il Route Number,	City or Town,	State, Zip	Code)
	1 and 2 Health tem 27 I		Beth Sullivan (Wife)		) Keswick		altimore			
ore	of He of He if item or oth		20a. Method of Disposition 1XXBurial 2 □ Cremation 3 □ Removal from State	Ob. Place of Dispo cemetery, cre-	osition (Name of matory or other pla	ce)	Date 2	0c. Location -	City or To	own, State
Ē	Pa ner ant: ury		'4 □Donation 5 □ Other (Specify)	orraine	Park Cem	etery 6/2	26/04	Woodlaw	n, M	aryland
Baltimore,	permit. Pages 1 and: Department of Health Important: If item 27 any Injury or other tr once.		21. Signature of Funeral Service Coensee	2	2. Name and Addre	ess of Facility	Funono 1	Цото	Tno	
<u>m</u>	897 2 2		Dece & Casanta		363I Fall	nss-Seitz s Road - I	Baltimor	e. Mary	land	21211
	Physician /Medical Examiner	ilner	23. Part 1. Enter the disease, or coing lications that caused the hock, or he in failure. List only the cause on each line. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Uruary ing Cause (Disease or injury)	Om a - I	nalgna	1				Interval Between Onset and Death
Box 68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical Examiner	that initiated events resulting in death) Last  C. Due to (or as a co d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	egnancy Fetal death 3[	□Ectopic pregnanc: □ Other (specify)	y		23d. Dat Mor		ery Day Year
o.	that the de led by the a detached f	ιλsi	9 Unknown		10					
rds, P.	w requires that been signed b should be defa	ed by PI	Part II. Other significant conditions contributing to death but no Deabetes Melitus	t resulting in the u	underlying cause giv	ven in Part I.	23e. Did tob	1.		ne cause of death?
Records,	The law requisate has been page 2 should	Completed by					24a. Was an autopsy perform	ed?	Vere auto rior to co leath?	psy findings available mpletion of cause of 2 No
of Vital	Physicien: Th r this certificate ral director, pag	Be (	25. Was case referred to medical examiner?			26. Place of Death	(Check only one	)		
>	Physic this ce al dire	To I	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient	2 ER/Outpatie		4   Nursing Ho	me 5 Reside	nce 6 Othe	er (Specif	y)
n 0	ding Pa		27. Manner of Death 1	er) 28b. Time o	Wo		28d. Describe ho	v injury occurr	be	
Division	Attending or death. ector: After by the fune	Certification:	2 Accident investigation			Yes 2 No				
. <u>≤</u>	r Att ter de Irect	ıtıff	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 28e. Place of Injury - building, etc. (S	At home, farm, st pecify)	reet, factory, office		28f. Location (Str. City or Town,		er or Rura	l Route Number,
	ital o					<u> </u>				
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier (Check only one)  Certifying Physicien: To the best of m 2 Medical Examiner: On the basis of examiner and manner stated.		ivestigation, in my o	opinion, death occurr	ed at the time, da	te and place, a	ind due to	the cause(s)
	To the within 2 To the comple	Σ	29b. Signature and title of certifier		29c. Licens		29	d. Date signed	Month,	Uay, Year)
•	17		Buts 4. July		D33	1770		6124	104	
	10		30. Name and address of person who completed cause of death	_ ~	1 0-	2.	40 00 - 1-	01	7 ( )	
			Dr. Betsy FAM 3		alls RE	) DAK	10, WI	) 210	Y/	
	∂ Sta		31. Date filed (Month, Day, Year)  32. Registrar's	Signature	,					
	Regist	ar	JUN 2 9 2004 Berein		Souls					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. Nø. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** William Frederick Schmick, Jr. 12:05P M June 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner Baltimore** Blakehurst Life Care Community Towson 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 N 2 F Months Days Hours Min Director 452-03-8461 90 December 3,1913 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 28e-f show 10d. Inside City Limits treumetic evant, the Medical Examiner must be notified at 1 ☐ Yes X No Maryland Baltimore Towson Direct 10e. Street and Number 1055 West Joppa Road 10f. Zip Code 10g. Citizen of What Country? ö 21204 USA or Itams 23e death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X X to If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ White 3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: Specify. natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Publisher Newspaper othar 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fi and Mental H is marked otl William Frederick Schmick Nancy G. Reindollar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Importent: If itam 27 is any injury or other treu once. John E Schmick Son 1100 Somerset Place Lutherville, Maryland 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 Other (Specify) Druid Ridge Cemetery 6/28/04 Pikesville, Maryland 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc.
4500 York Rd Baltimore, MD 21212 nature of Funeral Service Licenses my) Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** STOKE month disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Ch 50 mic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner that the death certificate be executed Congestive heart that initiated events resulting in death) Last physician ar s the burial-tr Due to (or as a consequence of): Box 68760 Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. the þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ rold 13 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s Jas autopsy performed certificate 1 ☐ Yes 2 ☐ No Division of Vital 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Plage of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 10 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manual of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Medical Certification: 28d. Describe how injury occurred After tha Hospital or Attanding 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide To the Hospital of within 24 hours at To the Funaral Completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 6-25-04 D 42129 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6301 N. Charles Baltomare MS D. Mc Connell MD William 31. Date filed (Month, Day, Year) ,32. Registrar's Signature JUN 2 9 2004 Registrar

29d. Date signed (Month, Day, Year)

TIMONIUM, MD 21093

	State of Maryland / Department of Health and N	lental Hygie	ne n	1.	201.00
te jistrar	Certificate of Death	Reg.		나	4.040
dent's Name (First, Middle, Last)		2. Date of Death	0		3. Time of Deat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physician	
/Medical	
Examiner	4

**Funeral** Director

a.m.

2:55

JUNE 28, 2004

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Itams 23a or 28a-f ahow ampriatury or other traumatic avent, Ita Marical Examinations to the rectilised at once. Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examin Division of Vital Records, P.O. Box 68760

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attanding Physician: The law requires that the death certificate be executed

DOROTHEA SMOOT

_	Decedent's Name		, Last)						2. Date Mont	of Death	Day	Year	3. Time of	Death	
n al	Dorothea A	. Smoot								28, 20	)4 )4	rear	2:55 A	М	
r	4a. Facility Name (/	f not institution,	, give street and nu	ımber)		4b. City,	Town, o	Location of C	Death		4c. County	of Death			
	Stella Mar	is Hospic	æ			Tin	nonium	า			Balti	more			
	5. Social Security N 219-01-2774		6. Sex 1 ☐ M 2 ☑ F	7. Age (In y	rs. last birtho	Months	n 1 Year Days		Min. 8. Date (Mont	of Birth th, Day, Ye, CY 1,	1918	9. Birthpl Count Mary la	lace (State or try) and	Foreign	
	Usual Residence of														
_	10a. State	10b. County		10c.	City, Town						10d. Inside City Limits				
cto	Maryland	N/A	\		Balti	more							1 X Yes	2 🗌 No	
al Dire	10e. Street and Nur 5413 Cynth		œ			10f. Zip	Code 21206	5		10g.	Citizen of V USA	What Coun	try?		
Be Completed by Funeral Director	11. Marital Status 1 ☐ Never Marri 3 ☐ Widowed		Armed F	2 <b>)()</b> (No	ı U.S.	13. Was Decer If Yes, sper 1 \( \text{Yes}	cify Cuba	ispanic Origin n, Mexican, P Specify:	? (Specify Yes Juerto Rican, etc	or No-	14. Race - American I Black, White, etc. Specify: White				
leted	(Spec	15. Decedent ify only highes	's Education t grade completed)		1 (0	ecedent's Usua Give kind of wo fe. DO NOT us	rk done i	durina most of	working	16b.	Kind of B	usiness/Ind	lustry		
dmo	Elementary/Seco 9th	ndary (0-12)	College (	1-4or 5+)	1	Offic					Cred	it Comp	oany		
e C	17. Father's Name	(First, Middle, L	_ast)					18. Mother's	Name (First, M	liddle, Maid					
IO E	William Bar	rdroff						Elizabe	eth Bachm	an					
	19a. Informant's Na Grayson M.					lailing Address  S Cynthia						Code)			
	20a. Method of Disp			20b	D. Place of D	isposition (Nar crematory or o	ne of	el l	Date	20c.	Location -	City or Tov	wn, State		
1	¹ 4 □ Donation	5 Other (Sp		Pa	rkwood	Cemetery	metery 6			Bal	ltimore	e Mary1	and		
	21. Signature of Fu	neral Service L	icensee Christ	tina L.	Hilton	Leonard 5305 Ha	d Address I J. F irforc	is of Facility Luck Inc Road E	Båltimore	Maryla	and 21	1214			
	shock, or hea Immediate Cause ( disease or condition resulting in death)	rt failure. List o Final n	aEND_ Due to	b.  Due to [or as a consequence of]:  Discations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line.  END STAGE DEMENTIA  Due to (or as a consequence of):  Due to [or as a consequence of]:									Approximate Interval Betw Onset and Do		
ician/medical Examiner	cause. Enter Unde Cause (Disease or that initiated events resulting in death) t	rlying injury	с.	(or as a cons	47										
ysician/me	IF FEMALE: 23b. Was decedent in the past 12 1 Yes 2 C	months?		ointh 2 □ Fe nant at time o	etal death	3 ☐ Ectopic pr 5 ☐ Other (sp					23d. Dat Mor	e of deliver	y Day Ye	ar	
ea by Phys	Part II. Other signif	icant condition	ns contributing to d	eath but not r	esulting in th	e underlying c	ause give	on in Part I.		Did tobacco	_		cause of dea		
Completed						24a. Was autor perfo					P		sy findings av pletion of cau		
lo De	25. Was case reference examiner? 1 Tyes 2 X		Hospital:	Inpatient 2	□ ER/Outpa	ıtient 3 DO	Othe	r	Death (Check o		6 □Othe	er (Specify)			
HOU:	27. Manner of Death  1 XNatural	n 5 ☐ Pending investig		of Injury th, Day Year)											
dical certification:	2 Accident 3 Suicide 4 Homicide	6 Could no	ot be 28e. Place	of Injury - At ing, etc. (Spe		ome, farm, street, factory, office 28f. Location (S					on (Street and Number or Rural Route Number, Town, State)				
Salcai C	29a. Certifier (Check only one)	1X Certifying 2 Medical E	Physician: To the examiner: On the b and man	best of my k asis of exami ner stated.	nowledge, dination and/o	eath occurred rinvestigation,	at the tim	e, date and pl inion, death o	ace, and due to	the cause( ime, date a	s) and ma nd place, a	nner as sta and due to t	ted. he cause(s)		

State Registrar 29b. Signature and title of certifier

DR. TARIQ MAHMOOD

31. Date filed (Month, Day, Year)
JUN 2 9 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2300 DULANEY VALLEY RD.

		1 - For State Registrar	State of Maryland		nent of H icate of I			giene Rog. Ng? () ()	4 20481
Physici		Decedent's Name (First, Middle, Last,	Rita D. Smia	lkowski			2. Date of Dea Month	Day	Year 8:38 P
./Medic Examir		4a. Facility Name (If not institution, give Genesis Heritage			-	Location of De ndalk		4c. County of	
Funeral Director		213-28-1326	7. Age (In yrs. Ia.		Under 1 Year onths Days	If Under 24 Hi Hours Mi			9. Birthplace (State or Foreign Country) Maryland
Maryland f show	ior	Usual Residence of Decedent  10a. State 10b. County  Maryland Balt:		Town or Location		dalk			10d. Inside City Limits 1 ☐ Yes 2 🛣 No
with the a or 28a-	Director	10e. Street and Number 1902 Frames Road		1	Of. Zip Code		1222	10g. Citizen of W	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department: if them 27 is marked other than "naturel; or Items 23a or 28a-f show any injury or other treumatic event. If a Medicul Exacit me India be rediffed at once.	Funeral	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give		Decedent of His, specify Cuba		Specify Yes or No- rto Rican, etc.)	14. Race Black	ed States - American Indian, c, White, etc. White
72 hours 'naturel',	eted by	35 Widowed 4 □ Divorced  15. Decedent's Edu (Specify only highest grad	Year or Dates:	16a Decedent	s Usual Occupa		orking I	Specify:	
ed within /giene. er then "	Completed	Elementary/Secondary (0-12) 8 Years	College (1-4or 5+)		Maker			Own	Home
uld be file Mental Hy arked oth	To Be	17. Father's Name (First, Middle, Last)  ROCCO Cusato					ame <i>(First, Middle,</i> a Salvi	Maiden Surname	<i>J</i>
and 2 sho laith and 127 is m		19a. Informant's Name/Relationship (Ty Mrs. Dawn M. Smi	alkowski	6925 D	elvale	Place D	Rumal Route Numbe undalk, N		. , ,
Pages 1 and of He not: if Item ry or oth		20a. Method of Disposition  1 Surial 2 Cremation 3 F  4 Donation 3 Other (Specify)	IGITION AT ITOTIC STATE	ce of Disposition metery, cremator wnsvill		- 1	Date 29/2004		City or Town, State
permit. Departm Importe any inju		21. Signature of Funeral Service Licens		22. Na Dud	me and Addres a-Ruck	s of Facility Funeral	Home of	Dundalk	, Inc.
Physician		23a. Part1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition	cations that caused the death. he cause on each line.		e mode of dying		ac or respiratory ari		Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a consequé  MAL NOT	ence of:	101			··	
cuted on a	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Pye to (or as a conseque	ance of):	UZE				
cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a conseque	ence of):	y				
The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 mop Ms? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnand 1 Live birth 2 Fetal d 4 Pregnant at time of dea	leath 3□Ecto	opic pregnancy er (specify)			23d. Date Mont	
quires that the de	by	Part II. Other significant conditions con	ntributing to death but not result	ing in the under	ying cause give	on in Part I.			oute to the cause of death?
	Completed						24a. Was a autops perfort	ned? pri	ere autopsy findings available for to completion of cause of ath?
clan: ertific	Be	25. Was case referred to medical examiner?					ath (Check only or	0)	
ding Physi n. After this c funeral dire	n: To	27. Manner of Death		R/Outpatient 3 8b. Time of Injury	DOA Othe	4 Nursing	Home 5 Reside	ence 6 Other	
or Attending F after death. Director: After in by the funera	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At hom	N	1 1 Y	res 2□No			or Rural Route Number,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certified completely filled in by the funeral director;		4   Homicide	building, etc. (Specify)	edge, death occ	urred at the tim	e date and plac	City or Town		nor ac stated
To the Hospitel within 24 hours a To the Funeral I completely filled	fedical	(Check only 2 Medical Exami	ner: On the basis of examinatio and manner stated.	n and/or investig	ation, in my op	inion, death occ	urred at the time, d	ate and place, an	d due to the cause(s)
To Non Yell	Σ	29b. Signature and title of certifier	James &	(1)	29c. License	7/88		9d. Date signed (	(Month, Day, Year)
り		30 Name and address of power who co	mpleted eause of death (Item 2	2/0	4st	7/40	P De	week s	15 2/222
Sta Registr		31. Marie filed (Month, Day, Year) JUN 2 9 2004	A2, Registrar's Signatur	re Allande					

			1 - For State Registrar	ledla 1 - ant		Marylan		artmen rtificat			and N	Mental Hy	Reg. No.	2001	20	82
	Physici /Medio Examir	cal	Decedent's Name (First, Mic LEROY M. SMITE     4a. Facility Name (If not institut	1		per)		4b. City,	Town, or	Location	of Death	June June	27 Day	ZDOL County of D	7 2:55	P. M.
	Examir	ier	NORTH ARUNDEL						en bi					NNE ARU		
6	Funeral Director		5. Social Security Number <b>214.22.9795</b>	6. Sex	7.	Age (In yrs.	last birthday) Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da JULY 14,	th ly, Year) 1927	9.	Birthplace (Stete or a Country) MARY LAND	Foreign
	and		Usuel Residence of Decedent  10a. State 10b. Coun	ty		10c. Cit	ty, Town or Lo	ocation							10d. Inside City	Limits
	Marylan -f show ied at	jo	MD ANI	IE ARU	INDFI	G	LEN BURI	NIE							1 □ Yes 2	XX ^{No}
	r 28a	Director	10e. Street and Number					10f. Zip	Code				10g. Citi	zen of What	Country?	
	th wit	a D	307 PHELPS AVE					21	1060				UNI	TED STA	NTES	
21215-0036	ages 1 and 2 should be filed within 72 hours atter death with the Maryland nt of Heath and Mental Hygiene.  If Item 27 is marked other than "natural", or Itams 23a or 28a-f show or other treumatic event, tra Medical Examinat required to notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ M 3 ☐ Widowed 4 ☐ Divorc	arried	12. Was Decede Amed Force 1 Yes 2 If Yes, Give Year or Date	es? □No		Was Deced If Yes, spe 1  Yes		ispanic Ori n, Mexicar Specify:		ecify Yes or No Rican, etc.)	-		vmerican Indian, Vhite, etc.	
5-0	72 hc	eted	15. Deced (Specify only high				(Give	dent's Usu kind of wo	rk done d	<i>furing</i> mos	t of work	ting	16b. Ki	nd of Busine	ess/Industry	
121	within ene. than "	Completed	Elementary/Secondary (0-12	)	College (1-4	lor 5+)		DO NOT u		•				C CO46	T CHADD	
	Hygie Hygie ther i	e Co	17. Father's Name (First, Middle	e, Last)			SIAI	IONARY	ENGII		er's Nam	e (First, Middle,			ST GUARD	
lan	Mental Mental arked o	To Be	JOHN WALTER SMI							ELL	A CAN	NON				
Maryland	nd 2 should lith and Men 27 is marke r treumatic	I	19a. Informant's Name/Relatio	nship (Ty		SON	1			an <i>d Numbe</i>	er or Rur	al Route Numbe		r Town, Stat	e, Zip Code)	
Baltimore,	ages 1 and int of Health 1: If Item 27 y or other tr		20a. Method of Disposition  1 □ Burial 2 XX rematio  4 □ Donation 5 □ Other	n 3 □R		ate 20b. F	Place of Dispo cemetery, cre	osition (Nai matory or c	me of other plac	θ)		Date	20c. Lo	cation - City	or Town, State	
Baltir	permit. Pages Department of Importent: If I any injury or once.		21. Sign or Funeral Service  KFLLY CRECORY	ce Lice	in l		F	2. Name ar I <b>NK FU</b> I	nd Addres	HOME,	P.A.	1, 2004		.TIMOKE,	סורוט	
	Pnysician /Medical Examiner		23a. Part 1. Enter the disease, shock, or heart failible. L Immediate Cause (Final disease or condition resulting in death)	of compli	ications that cau	sed the deat		ter the mod	te of dyin	g, such as	cardiac		rrest,		Approximate Interval Betwe Onset and De	een eath
1760,	ite be executed ysician and ne burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		) ).	as a consec			<i>V</i> 1							
.O. Box 68	that the death certificate be executed by the attending physician detached for use as the buria	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	2		h 2 Fete	el death 3[	⊒Ectopic p					4	23d. Date of Month	delivery Day Ye	ar
rds, P		b	Part II. Other significant cond		ntributing to dea Merch			riderlying o		en in Part I			obacco u Yes 2[		e to the cause of dea	
al Records,	: The law requires cate has been sign : page 2 should be	Completed	· ·				/					24a. Was autop perfo 1 \( \text{Yes} \)		24b. Were prior death		railable use of
Vital	Physician: Th r this certiticate ral director, pag	Be	25. Was case referred to medi examiner?		lospital:		150/0		Othe	ar-		h (Check only o		. 7.6		
of	fune fune	tlon; To	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pen 2 Accident inve		28a. Date of		28b. Time of Injury		28c. Injun Worl	4   NU		ome 5 Resident			Specify)	
Division	al or Attending atter death. I Diractor: After d in by the fune	Certification;	3 Suicide 6 Cou	ld not be rmined	28e. Place of building	f Injury - At h j, etc. <i>(Speci</i> i	ome, farm, st	reet, factor	y, office			28f. Location (S City or Tox			r Rural Route Numbe	91,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 Certifier (Check only one) 1 Medic	ying Phys el Examin	sician: To the b ner: On the bas and manne	is of examina	owledge, deal ation and/or in	th occurred evestigation	at the tin	ne, date an pinion, dea	d place, th occur	and due to the red at the time,	cause(s) date and	and manner place, and o	r as stated. due to the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of cert	fier	,			29	c. License	2 6 7 ·	٦		29d. Dat	e signed (Mo	onth, Dey, Year)	
	1		30. Name and address of pers	on who co	ompleted cause	of death (Iter	m 23a) (Type	Print)	١١.	<i>&gt;   </i>	/		سا ل	e	1) 2004	
	1,		31. Dale filed (Month, Day, Ye	Two	m - 301	#p≤ gistrar's Signa	RM attribute	BR	ie,	Gler	( E	sume	. <i>Y</i>	no.	2106/.	
	St Regist	ate rar		200/	Lake	مهاسمه	A	Lac	10.0							

# unpend item#23a,Part II,27,PER ME,G833,7/8/04eg Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygion

*		1 - For State Registrar  1. Decedent's Name (First, Middle			rtificate of De	eath	Reg.	0001	20483
Physic		ROSEMARY T. SOTELO	•			2.	Month	Day Year	3. Time of Death
/Medi Examil		4a. Facility Name (If not institution, 152 Mill Cree)	give street and number)		4b. City, Town, or Lo Perryvil		June 20	4c. County of Death Cecil	1230 p ^h
Funeral Director	Ş		6. Sex 7. Age (In	yrs. last birthday) +2 Yrs.	If Under 1 Year   If	Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Day, Ye	ar) 9. Birth	place (State or Foreigntry)
		Usual Residence of Decedent					JUNE 10, 19	962 PH0EN	IIX, AZ
the Marylan 28a-f show nylliled at	tor	10a. State 10b. County		c. City, Town or Lo	cation				10d. Inside City Limits  1 Yes 2 □ No
the 28a	Director	AZ MAR I 10e. Street and Number	COPA	PH0ENIX	10f. Zip Code		100	Citizen of What Cour	
3 with		1324 W. PECAN ROAD			85041		log.	UNITED STA	
ter death w Items 23c	Funeral	11. Marital Status	12. Was Decedent Ever	'in U.S. 13.1	Was Decedent of Hispa f Yes, specify Cuban, N	unic Origin? (Specify	y Yes or No-	14. Race - Americ	
72 hours after death with the Maryland 72 hours after death with the Maryland Insturel', or Items 23e or 28e-f show also Example invited ut	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1 Yes 2 No If Yes, Give XX Year or Dates:		f Yes, specify Cuban, M XXX Yes 2☐ No S			Black, White, Specify: WHIT	etc.
72 hours "natural",	ted	15. Decedent' (Specify only highest	s Education	16a. Dece	lent's Usual Occupation	n		Kind of Business/In-	
be filed within 72 he tall Hygiene. Ind other than "nature event, the Mexical	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done durir OO NOT use retired)	ng most of working			,
an yiailia 2 12 1 2 should be filed within and Mental Hygiene. is marked other than " aumatic event, Ire Ma	် ပ	12	2	H	OMEMAKER			OWN HOME	
be fill tal Hy od oth	Be	17. Father's Name (First, Middle, L	ast)		18.	Mother's Name (F	irst, Middle, Maid	len Sumame)	
es 1 and 2 should be 1 Health and Ment of Health and Ment of tiem 27 is marked rother traumatic e	은	JESSE SOTELO				MARGY VANNA			
2 sh and is m		19a. Informant's Name/Relationsh	р (Турө, Print)	19b. Mailir	g Address (Street and	Number or Rural Re	oute Number, City	y or Town, State, Zip	Code)
and and tealth m 27		SABRINA SOTELO			1 W. 2ND ST.				
Defitilities (1) Wat yield (2 / 1 / 13-0030)  bermit. Pages 1 and 2 should be filed within 72 hours alt Department of Health and Mantal Hygiene.  mportant: If item 27 is marked other than "natural", or my injury or other traumatic event, the Marial Examinate.		20a. Method of Disposition  1 Burial 2 XX remation  4 Donation 5 Other (Sp	XX Removal from State		sition (Name of natory or other place) ORTUARY SRVS	Date unk	200.	Location - City or To	wn, State
permit. Pag Department Important: It any injury o		21. Signally Truneral Service L	Jane -	22 F1	Name and Address of NK FUNERAL HO	Facility ME, P.A.			
		23a. Part1 Enter the disease, occashock or heart failure. List of	FINK M011  mplications that caused the historie cause on each line.	death. Do not ente	6 CRAIN HWY S or the mode of dying, su	uch as cardiac or re	spiratory arrest.	J61	Approximate Interval Between
Pnysician /Medical		Immediate Cause (Final disease or contion resulting in death)	a. Due to (or as a cor		scular Diseas	e			Onset and Death
Examiner	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b Due to (or as a cor	nsequence of):					
be executed ician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a cor						
g physician a	Medical E		d.	isequence of);					
artifica ing ph	Med	IE EENAN E							
death ce e attend	Physician/A	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pro 1 □ Live birth 2 □ I 4 □ Pregnant at time 9 ■ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliver Month	ry Day Year
w requires that the been signed by the should be detached.	by Pr	Part II. Other significant condition Hepatitis C Infect:	s contributing to death but not	t resulting in the un	derlying cause given in	Part I.	23e. Did tobacco	use contribute to the	e cause of death?
requires een sign	ted						1 ☐ Yes	2 □ No 3 □ Proba	ıbly 4 <b>Q</b> unknown
e la has	Completed by						24a. Was an autopsy performed?	prior to com death?	sy findings available
yalcian: Th is certificate director, pag	Bec	25. Was case referred to medical examiner?			26.	Place of Death (Ch	Yes 2□N	lo 1 Xyes	2 🗆 No
Phyalcian: this certific	101	1. XYes 2 No	Hospital: 1 Inpatient	2 ER/Outpatient				6 ☑Other (Specify)	at scen
ding P. After fune	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	28a. Date of Injury (Month, Day Yea tion	28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes	28d.	Describe how inju	ury occurred	at scen
al or Attending safter death. I Director: Afte d in by the fune	ertific	3 Suicide 6 Could no 4 Homicide determin		At home, farm, stre	et, factory, office	28f. I	Location (Street a City or Town, Stat	and Number or Rural te)	Route Number,
To the Hospital or Attending I within 24 hours after death. To the Funeral Director, After completely filled in by the funer	edical C	29a. Certifier (Check only one)  1 Certifying 2 Medical Ex	Physician: To the best of my aminer: On the basis of examiner and manner stated.	knowledge, death nination and/or inve	occurred at the time, da estigation, in my opinion	ate and place, and on, death occurred at	due to the cause(s the time, date ar	s) and manner as stand place, and due to t	ted. the cause(s)
To the I within 2 To the Complet	X	29b. Signature and title of certifier	•		29c. License nun OCME			ate signed (Month, D	
		30. Name and address of person w	RUBIO , M.P.	(Item 23a) (Type, P	rint) 111 Peni	n Street,	Baltimo	ore, Maryl	and 21201
Sta ` Registra		31. Date filed (Month, Day, Year)	32. Registrar's Si	ignature					
- registi		JUN 2 9 20	IIA MARIA	A. P. STATE	No. of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of				

			1 - For State Registrar	State of Maryla		artment of	Health and I	Mental Hygie		
			Registrar  1. Decedent's Name (First, Middle, Last)	]	Ce	rtificate of	Death	Reg.	No:	201.01
	Physici		PHULLIC		ERN	All		Month	Day Year	3, Time of Death.
	/Medic Examir		4a Facility Name (If not institution, give :		2,00		or Location of Death	06	4c. County of Deal	14 5:3014"
			COLLINGTON EF	PISCOPAL LI	ECARE	MITTO	HELLUI	U.F.	P.6.	
	Funeral		5. Social Security Number 6. Sec		. last birthday)	If Under 1 Yea Months Days	r If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye		thplace (State or Foreign
	Director		Usual Residence of Decedent	7	13 Yrs.			64/03/		SBURGH, PA.
	yland		10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits
	e Mar	ctor	MV) P.G.	m.	ITCHE	ZWILL				1 ☐ Yes 2 📈 No
	with th	Dire	10e. Street and Number	0. 00		10f. Zip Code	7-7		Citizen of What Co	ountry?
	eath v	by Funeral Director	1	RO RO	1.0	4 5	2072		USA	
(0	ritan Ilian	Fun	11. Marital Status  1 □ Never Married 2 □ Marned	12. Was Decedent Ever in U Armed Forces? 1 □ Yes 2 N No			Hispanic Origin? (Sp ban, Mexican, Puerto	Rican, etc.)	14. Race - Ame Black, White	
8	ral', o	l by	3 Widowed 4 □ Divorced	1 ☐ Yes 2 M No If Yes, Give Year or Dates:		1 □ Yes 2 No	Specify:		Specify: W	HITE
21215-0036	within 72 hours after death with the Maryland ene. than "netural", or itams 23s or 28s-1 show fra Medical Examination in Italias at the motified at	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	(Give	dent's Usual Occu kind of work done	during most of world	sing 16b	. Kind of Business/	Industry
72	withir ene. than	mc	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	AGENT		NA	
	illed Hygi other	Be Co	17. Father's Name (First, Middle, Last)		1 1-4-	1000 /		e (First, Middle, Maid	den Sumame)	
/lar	uld be Venta Irkad Itic ev	To B	PHILIP H /	NAYER			IDA	GOTTLIE	B MA	TER
Maryland	2 sho and I s ma	ľ	19a. Informant's Name/Relationship (Ty)	pe, Print)				al Route Number, Ci	ty or Town, State, Z	
	f and Health Im 27		Henry Baer/nephew  20a. Method of Disposition	205		market by the same	-	k, New Yo		
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or itams 23a or 28e-f show amy injury or other traumatic event, the Medical Expedition and be notified at once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ R		cemetery, cren	sition (Name of natory or other pla	ace)	Date 20c	. Location - City or	Town, State
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ñ	Depa Impo any i		21. Signatur Anneral Service License Ronal C S W	ade			MD 2120	655 W. Ba	altimore	Street
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	Physician		Immediate Cause (Final disease or condition	Chronic	0601	r winy	c full	1000	) (de ce 2e	Onset and Death
100	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):					
¥	ž.	0	if any, leading to immediate cause. Enter Underlying	Due to (or as a consec	uence of					
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ó	be executed sicien and burial-transit		resulting in death) Last	Due to (or as a conseq	quence of):					
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Вох	attend for us	sian	in the past 12 months?	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	al death 3	Ectopic pregnanc	у		23d. Date of deliver Month	very Day Year
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ري ت	law requires that the as been signed by th 2 should be detache	by PI	Part II. Other significant conditions con-	tributing to death but not res	sulting in the un	iderlying cause gi	ven in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
ecords,	w requires that been signed t should be det	pel k						1 ☐ Yes	2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	bably 4 Unknown
ဝင	law ras be	Completed						24a. Was an autopsy	24b. Were aut	opsy findings available ompletion of cause of
	: The lav cate has page 2:	Con						performed	death?	
Vital	÷ 0 E	Be	25. Was case referred to medical examiner?	ospital:		O#		(Check only one)		
ō	y Phys or this oral di	); To	1 Yes 2 No	28a. Date of Injury (Month, Day Year)	ER/Outpatient	3 □ DOA □ 000   28c. Injur	4 Nursing Ho	me 5 Residence 28d. Describe how in	6 Other (Speci	ify)
DIVISION	death. ctor: After y the funer	ation:	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Wo	rk? Yes 2 □ No		jary osoanog	
<u>s</u>	of or Attendated after death	Certificati	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, stre	et, factory, office		28f. Location (Street City or Town, Sta	and Number or Rui	ral Route Number,
ב	ortal ors aft								,	
:	To the Hospital or within 24 hours after To the Funeral Dire completely filled in b	edical	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examin	ician: To the best of my knower: On the basis of examina and manner stated.	owledge, death ition and/or inv	occurred at the tire estigation, in my o	me, date and place, pinion, death occurr	and due to the cause ed at the time, date a	(s) and manner as and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	/1		29c. Licens			Date signed (Month,	
ľ			I whald he	1 1.3		225	970	(0	1157-1	
			30. Name and address of person who con	1 1	n 23a) (Type, F	Print)				20704
			31. Date filed (Month, Day, Year)	author mo	7404		ANGLE P	. Lon	herman pos	o fair
	Stat Registra	30	IIIN 9 Q 2004	7. Registrar's Signa	ture for	B. j				

			1 - For Stata Registrar	State of Maryla	•		of Health a	ind Mer		i. v <mark>i</mark> 3. () (		201.25
			1. Decedent's Name (First, Middle, Last)						Date of Death	100-10	1 65	3. Time of Death
м	Physici /Medic		Leonard L. Sohn,	Jr.					Month	Day	Year )	8:34 P M
L.	Examir		4a. Facility Name (If not institution, give s	street and number)		4b. City, Tow	n, or Location of		20110	4c. County	of Death	0.0,
			Stella Maris Hos	pice of Merc	ey.	Balt	imore					
	Funeral		5. Social Security Number 6. Sex	7. Age (In y	rs. last birthday)	If Under 1 Yo	ear if Under 2 ays Hours	24 Hrs. 8. Min.	Date of Birth (Month, Day, Y	(par)	9. Birthpl Coun	ace (State or Foreign
	Director		215-70-0318	M 2□F	49 Yrs.	Montais	iys Hours	J	une 12,	1955	Mary	
	ը ,		Usual Residence of Decedent  10a. State 10b. County	10.	Oit. Town 1							
	sho	_			City, Town or Lo	cation					10	Od. Inside City Limits
	8a-f	ctc	Maryland Baltimor	re	Caton	sville						1 ☐ Yes 2 ☑ No
	with t	i i	10e. Street and Number			10f. Zip Cod	de		10g	. Citizen of V	Vhat Coun	try?
	s 23s	Funeral Director	120 Wyndcrest Ave				21228				S.A.	
	er de Itam	nue		12. Was Decedent Ever in Armed Forces?	10.5.	Was Decedent If Yes, specify (	of Hispanic Orig Cuban, Mexican,	in? (Specify , Puerto Rica	Yes or No- an, etc.)		e - America k, White, e	
36	rs aft	by F	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ♣ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑	No Specify:			Specify	Wh	ite
21215-0036	within 72 hours after death with the Maryland ene. than "neturel", or items 23a or 28a-f show the Mudical Exertiner challes incillised at	edt	15. Decedent's Educ		16a Decer	dent's Usual Oc	cupation		16	b. Kind of Bu		
5	in 72	Completed	(Specify only highest grade	completed)	(Give	kind of work do	one durina most	of working	10	o. Kind of Bi	isiii essiiid	ustry
72	with iene	E O	Elementary/Secondary (0-12)	College (1-4or 5+)	Opera	tions M	anager			Td Por	. Amı	sements
D	filed Hygie other ent, II	Be C	17. Father's Name (First, Middle, Last)		Topera	<b>e z</b> o i i o		's Name (Fi	rst, Middle, Ma			isements
<u>a</u>	should be and Mental I	To B	Leonard L. Sohn,	Sr.			Dor	ie Eli	izabeth	Lauma	n	
Maryland	iges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene.  If item 27 is marked other than "neturel", or items 23a or 28a-f show if item 27 is marked other than "neturel", or items 23a or 28a-f show or other traumatic event, II a Medical Examinations.	-	19a. Informant's Name/Relationship (Typ		19b. Mailir	ng Address (Str	reet and Number					Code)
	1 and 2 Health a lem 27 ls		Susan D. Sohn	(Wife)		Wyndcre			nsville			
ē,	s 1 a f Hea item othe		20a. Method of Disposition	206	. Place of Dispo cemetery, cren			Date		c. Location -		vn, State
Ë	Pages nent of int: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re  `4 ☐ Donation 6 ☐ Other (Specify)		t. Paul			6-29-2	2004 B	altimo	ro M	lowul and
Baltimore,	그 문학 등		21. Signatu and Funeral Service License		22	. Name and Ad	dress of Facility	,				
Ö	Depa Depa Impo any ir	() y	23a. Part1. Enter the disease, or complice	N01290			uneral l ondson l				e, In	<u>\$</u> 1228
	Physician /Medical Examiner    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit    (the private transit	cai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause Elist Locations (Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons  Due to (or as a cons	equence of):	_ CAN	VCOR				-	Onset and Death  7. Manyth
P.O. Box 68	the death certific y the attending p ached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ➡ No 9 □ Unknown	3c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time o 9 Unknown	etal death 3	Ectopic pregna				23d. Date Mor	e of deliven	y Day Year
rds, F	w requires that been signed be should be det	by	Part II. Dther significant conditions conf	tributing to death but not r	esulting in the ur	nderlying cause	given in Part I.		23e. Did tobac		bute to the	cause of death?
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Vita	ysician: This certificate	Be	25. Was case referred to medical examiner?	anital.				of Death Ch	eck on one			
Division of	S 5	ition: To	1 Yes 2 No Pto  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. lr	Other: 4 Nurs	28d.	5 Residence Describe how i			hispice
Divis	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm, stre	et, factory, offi	се	28f. I	Location (Stree City or Town, S	t and Numbe tate)	r or Rural	Route Number,
	To the Hospitel or A within 24 hours after To the Funeral Directompletely filled in by	edicai (	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examin	ician: To the best of my k er: On the basis of exami and manner stated.	nowledge, death nation and/or inv	occurred at the restigation, in m	e time, date and ny opinion, death	place, and o	due to the caus the time, date	e(s) and mar and place, a	ner as stai	ted. he cause(s)
	To the within To the Comp	Me	29b. Signature and NIe of certifier			29c. Lice	ense number		29d.	Date signed	(Month, D	ay, Year)
			MICAN	11 (1)		12	4793	4	I	UNE	24	2004
_	10		30. Name and address of person who cor	dakis	30151	Print) PAU	PL	Balt	more			
	Sta Registr		31. Date filed (MeAth, Day, Year)  JUN 2 9 2004	32. Registrar's Sig	natura A	ooks	1					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2004 **Physician** JUNE 24, B. SALTZMAN FLORENCE 12:40 A M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death JEWISH CONVALESCENT CENTER BALTIMORE BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth MAR. 28, 1912 **Funeral**  Birthplace (State or Foreign Country) Months Days Hours 92 Yrs. 215-01-1045 Director MD Usual Residence of Decedent death with the Maryland 10a State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or Items 23s or 28e-f show any injury or other traumatic event, the MacIcal Examinar riust be notified at once. 10d. Inside City Limits Director BALTIMORE BALTIMORE 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7920 SCOTTS LEVEL ROAD 21208 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed by 3 Widowed 4 Divorced Specify WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BEAUTICIAN BEAUTY SALON 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be OSCAR SALTZMAN ပ GERTRUDE WEINBERG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, SAMMIE GOLDBERG / NIECE 11702 GARRISON FOREST ROAD - OWINGS MILLS, MD 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) ARLINGTON CHIZUK AMUNO 6/27/2004 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Eduma 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 1 KUM 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DEMENTIA - ALZHEIMERS 10 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): P.O. Box 68760 the attending physician Physician/Medical as the IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death Month Dav Year 5 Other (specify) ☐ Yes 2 No 9 Unknown 9 Unknown signed by t Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? Yes 2 No 1 Yes 1 ☐ Yes 2 ☐ No Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 X Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification; 28b. Time of 28d. Describe how injury occurred or Attending After Division 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funerel Director: 3 Suicide 6 Could not be in by t Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospitel 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. icai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 24/04 030377 30. Name and addressor person who completed cause of death (Item 23a) (Type, Print) Robert M. COOper MY 6503 PARIC Ave SALTIMORE MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature JUN 2 9 2004 Registrar

			1 - For Amend Item Registrar	2015tate of Maceana	oPPOP	tificate of	Health and		ene g. n/2. () () ()	20107
			Decedent's Name (First, Middle,	Last)			D Guiii.	2. Date of Death		3. Time of Death
	Physic /Medi		MARGARET	J THOMAS				JUNE	27 200 U	5135 pm
1	Exami		4a. Facility Name (If not institution, WNTV OF MD H	give street and number) OSPITAL			or Location of Deat	h	4c. County of Deat	A
	Funeral Director		212-46-4617	5. Sex 1 □ M 2 AF 7. Age (In yrs. la	Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day,	year) 9. Birt	hplace (State or Foreign untry) RVLAND
	land land		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "naturel", or items 23a or 28a-f show other treumatic event, If a Medical Examiner must be notified at	Funeral Director	MARYLAND  10e. Sveet and Number	NIA		BALT 101 Zin Code	1HORE 2120	City	g. Citizen of What Co	1ÆYes 2□No
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	death	nera	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13. V		Hispanic Origin? (S ean, Mexican, Puerl		14. Race - Ame	rican Indian,
5-0036	ours after rel', or ite Examine	by	1 □ Never Married 2 □ Married 3 ▼ Widowed 4 □ Divorced			Yes 2/10 No		o Hican, etc.)	Specify: 3/	a, etc.
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nd	be file d oth event	Be	17. Father's Name (First, Middle, La			1	18. Mother's Nar	ne (First, Middle, Ma		
Maryland	d Mental d Mental narked o natic eve	မ		ONEWALL JA			K03	ABELL	By.	RD
Ma	d 2 sho th and th and treums	18	19a. Informant's Name/Relationship  DESTREE THOM.		19b. Mailin	g Address (Street	and Number or Ru	-0	City or Town, State, Z	A COLUMN TO THE REAL PROPERTY.
ē,	of Health of Hem 27 i		20a. Method of Disposition	20b. Pla	ace of Dispos	sition (Name of	07/04		oc. Location - City or	0,2/3/3 Fown, State
E	9 - = =		1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe	Hemoval from State		atory or other pla		7 2004	ANSLOW	
Baltimore,	permit. Page Department o Importent: If any injury or once.		21. Sign flus of Fun al Service Li		22.	Name and Addre	ess of Facility	20000	JR. FUNE	The same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the sa
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			23a. Part1. Enter the disease, or co shock, or heart failure. List on	emplications that caused the death.  By one cause on each line.	Do not ente	r the mode of dyi	ng, such as cardiac	or respiratory arres	t,	Approximate Interval Between
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	uted d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	· CIPPHOS	_					
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		Med	IF FEMALE:							
Бох	death certific e attending p od for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnand	death 3 □	Ectopic pregnancy	/		23d. Date of deliver Month	very Day Year
o.		nysic	1 □ Yes 2 No 9 □ Unknown	4□Pregnant at time of dea 9□Unknown	in 5	Other (specify) _				,
σ,	The law requires that the ate has been signed by th page 2 should be detache	by Pr	Part II. Other significant conditions	s contributing to death but not result	ting in the un	derlying cause giv	en in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
ecords,	w requires been sign should be	ed b						1 🗆 Yes	2 □ No 3 □ Pro	babiy 4 Unknown
000	e law re has bee	Completed						24a. Was an	24b. Were aut	opsy findings available
$\alpha$	The ate has page	Com						autopsy performed	Drior to co	ompletion of cause of 22 No
Vital	Physician: Th this certificate ral director, pag	Be (	25. Was case referred to medical examiner?					h (Check only one)		
of \	Physi this c al dire	2	1 ☐ Yes 2 No		R/Outpatient	3 DOA Oth	er. 4 🗆 Nursing H	ome 5 ☐ Residenc	e 6 □Other (Speci	fy)
	fter free	tion	27. Manner of Death  1 ★Natural 5 Pending 2 Accident investigat	(Month, Day Year)	28b. Time of Injury	28c. Injur Wor M 1	yat k? Yes 2 ⊡No	28d. Describe how	injury occurred	
Division	or Attending after death. Director: After in by the fune	fica	3 ☐ Suicide 6 ☐ Could not	be ORe Bloom of leiver Ather	ne, farm, stre		163 2 100	28f. Location (Stree	et and Number or Rur	al Route Number
<u>S</u>	el or a after al Dire	Certification;	4  Homicide determine	building, etc. (Specify)		,,		City or Town, S	State)	ar riodio rombor,
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical C	29a. Certifier Certifying I (Check only one)	Physician: To the best of my knowl aminer: On the basis of examinatio and manner stated.	edge, death on and/or inve	occurred at the tinestigation, in my o	ne, date and place, pinion, death occur	and due to the caus red at the time, date	se(s) and manner as s and place, and due t	stated. o the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certifier			29c. Licens		29d.	Date signed (Month,	Day, Year)
	2		Menarla	1 MD		P14	1445		6/27/4	
	1		30. Name and address of perso		3a) (Type, P	rint)			-1-11	
			JULIA KHAI	eur 125	6RE	ENES	SI BAL	TIMOR	E, IIP .	21201
	Sta Registr		31. Date filed (Month, Day, Year) JUN 2 9 20	o completed cause of death (Item 2 LLP 2ZS Registrar's Signatur	Sec.	م				

)			1- State Amend item #23at, pot Mary 29nd Penarics 35 09 / 12 pt 1	and Mer h			201.00
			Decedent's Name (First, Middle, Last)		Date of Death	11.14	3. Time of Death
	Physic		KENVEL S. TAYLOR	<b>"</b> 3 –	Month	Day Year	
7	/Medi Exami		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location	3	lune	25 200 4c. County of Dea	
	Lxuiiii	ici					ın
2			Sinai Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff Under 1 Year I ff U			N/A	
3	Funeral		217.9/-213/2 1 M 2 F 23 Yrs. Months Days Hours	Min. 8.	Date of Birth Month, Day, Y		thplace (State or Foreign ountry)
4	Director		Usual Residence of Decedent		OV, 28,	1980 MA	RYLAND
,	and *		10a. State 10b. County 10c. City, Town or Location		/		
	aryla	-	N. A. A. A. A. A. A. A. A. A. A. A. A. A.	/	,		10d. Inside City Limits
	Ba-f	ct	MARYLAND NIA BALTIMO	PE C	ITV		1. Yes 2 □ No
	h th	Director	10e. Street and Number 10f. Zip Code			Citizen of What Co	ountry?
	38 G	<u></u>	3001 SPRINGHILL AVENUE 21	215		11 = -	
	death with the Maryland ms 23e or 28a-f ahow Frinst be notified at	Funeral		Prigin? (Specify	Voc or No	USP	s de la disc
	iter o	בַּ	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married  12. Was Decedent of Hispanic Or If Yes, specify Cuban, Mexica	an, Puerto Rica	n, etc.)	14. Race - Ame Black, Whit	
38	rs a	by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	y:		Specify:	. 0 1/
21215-0036	hou tura	pe				101	AUR
77	"ne	Completed	15. Decedent's Education (Specify only highest grade completed)  Flementary(Secondary (0.12)  College (1.465.5)	st of working	161	. Kind of Business	Industry
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핃	al H al H i oth	Be	17. Father's Name (First, Middle, Last)  18. Moth	her's Name <i>(Fir</i>	st, Middle, Mai	den Sumame)	7
<u></u>	uld t Ment rke tic s	2	NED WARD AP	RIL		Cox	LINS
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylar of Heatth and Mental Hyglene. Item 27 is marked other than "netural", or items 23e or 28e-f ahow other treumatic event, Its Medical Exarta activate the notified at		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Numb		ute Number Ci	ty or Town State	In Code
Š	tre		114 0 - 0 - 1 - 1 - 70 0 - 4 - 1		<i>a</i> 2		1 - 1 -
ď	1 ar Heal em 2		20a. Method of Disposition 20b. Place of Disposition (Name of				1, 2/2/5
Baltimore,	permit. Pages 1 and 2 Department of Health Important: If item 27 eny injury or other tre once.		1 Surial 2 Cremation 3 Removal from State	Date	200	Location - City or	Town, State
<u>=</u>	Pa men ant: ury		'4 □Donation 5 □Other (Specify) WOODLAWN CEMETERY	07-01.	-04 W	ODDI ATOM	MARWANN
ᆵ	permit. Pa Departmer Important eny injury		21. Signature of Funeral Service Licensee 22. Name and Address of Facility	lity Qa.		O Eiler	101 11 000
m	8 9 E 8 8		the sheek william JOSEPH &	DRO	AVA	BALTA	CAL HOINE
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as	441010	111000	OMLO: F	Approximate
	Physician /Medical Examiner	Examiner	Immediate Cause (Final disease or condition resulting in death)  Henorhage due to Vascular Lesion Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  C.	on of B	Retrope	ritoneum	Onset and Death
60,	or Attanding Physician: The law requires that the death certificate be executed after death. After death. After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit.		resulting in death) Last  Due to (or as a consequence of):				
8760	hysie the t	dicai	d				
9	death certifica attending ph d for use as t	Med	IF FEMALE:				
Box	th ce	Physician/Me	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	N 11		23d. Date of deli	/erv
-	dea e att	C	1 Pres 2 No. 4 Pregnant at time of death 5 Other (specify)	n births		Month	Day Year
P.O.	res that the de igned by the a be detached to	ys	9 ☐ Unknown			JUNE 15	2004
σ.	that led b		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		3a Did tobacc		2004 the cause of death?
of Vital Records,	sign d be	,a	History of twins intrauterine pregnancy		1 ☐ Yes		,
ō	w requir been s should	ete	P-Oguito		, , , , ,	2010 3010	bably 4 Unknown
ec	law as b s 2 s	ompleted		2	4a. Was an	24b. Were aut	opsy findings available
α:	an: The tificate ha tor, page	0			autopsy performed	death?	mpletion of cause of
ta	ician: Th certificate ector, pag	C	25. Was case referred to medical	a of Dooth (Oh	Yes 2	1 X Yes	2 No
>	ysicia is cert direct	0 B	examiner?	e of Death (Che		_	
of	Phy ral d	-				6 ☐ Other (Speci	(y)
n	ding F	Certification:	1 Matural 5 Pending (Month, Day Year) Injury Work?		escribe how in	jury occurred	
Division	ottandi death. ctor: A y the fu	cat	2 Accident investigation M 1 Yes 2 N	No			
:≦	after datter de Diract		3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Le	cation (Street	and Number or Rur	al Route Number,
	s aft	Ser	Building, Glo. (Opecny)		ity or Town, Sta	16)	
	To the Hospital within 24 hours a To the Funeral Completely filled	edicai (	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and and manner stated.	nd place, and du	e to the cause	(s) and manner as	stated.
	To the Hos within 24 h To the Fur completely		Will Marines States.	an occurred at 1	iie iiiie, date a	iiu piace, and due t	o tne cause(s)
	Vith vith com		29b. Signature and title of certifier 29c. License number		29d. D	ate signed (Month,	Day, Year)
			7 hand 11 % O.C.	M.E.	Jur	ne 25, 20	04
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			,	
		- 1					
_		_	THE DONE M. King 111 Penn Street,	Baltin	more, Ma	aryland 2	1201
						_	
	Sta Registra		JUN 2 9 2004  Registrar's Signature				

			1 - For State Registrar	State of Maryla		artment of rtificate of		d Mental H	ygiene Reg. NO. 1	0.1	20120
	Physic /Med		Decedent's Name (First, Middle, Las Mary Ambrosia	Vasold				2. Date of i	Death	2004	3. Time of Death
	Exami		4a. Facility Name (If not institution, give Maria Health Co			4b. City, Town, Baltim	or Location of D		4c. Cou	unty of Death	
	Funeral Director		5. Social Security Number 6. Sc 220–68–6309 1  Usual Residence of Decedent	9X 7. Age (In yrs	. last birthday) Yrs.	If Under 1 Year Months Days			Day, Year)	9. Birthp Coul	place (State or Foreign ntry) MD
	the Maryland 28e-f ehow notified at	tor	10a. State 10b. County Baltimo:		ity, Town or Lo					1	10d. Inside City Limits
	death with the M me 23a or 28e-f	Funeral Director	10e. Street and Number 6401 N. Charles	s St.		10f. Zip Code 2121	2		10g. Citizen	of What Cour	ntry?
920	hours after dea turat', or Iteme	ρ	11. Marital Status  **Twever Married 2   Married 3   Widowed 4   Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of f Yes, specify Cut 1 ☐ Yes 2 🛣 No		? (Specify Yes or Nuerto Rican, etc.)		Bace - Americ Black, White, cify: Whi	etc.
21215-0036	within 72 ane. than "ne	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retire	pation during most of od)	working		Business/Inc	dustry
Maryland 2	should be filed wind Mental Hygien marked other thematic event, the	To Be Co	17. Father's Name (First, Middle, Last)  Ambrose J. Vasc	old	1 000	104001		Nam <i>e (First, Middl</i>	e, Maiden Sum		schools
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Baltimore,	permit. Pages 1 a Cepcrtment of Hea In portent: If item any injury or othe		20a. Method of Disposition  1	Removal from State	cemetery, cren Lla Ma	sition (Name of natory or other pla	netery	Date 6/24/04	015243	n - City or To	para
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	Physician /Medical		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ine cause on each line.	ARD.	14L 1		-			Approximate Interval Between Onset and Death SAMB
	Examiner	iner	Sequentially list conditions, if any learing to minimize the cause. Enter Underlying Cause, Obsease or injury	bne to (or as a nonseq							
68760,	icate be executed physician and s the burial-transit	dicai Examiner	Cause (Disease or Injury that initiated events resulting in death) Last	c	uence of);						
O. Box	The law requires that the death certifica ate has been signed by the attending phr page 2 should be detached for use as th	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes ★★★No 9 □ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d	Ideath 3□	Ectopic pregnancy Other (specify)	,			Pate of deliver	'Y Day Year
Φ.	w requires that been signed b should be deta		Part II. Other significant conditions con	ntributing to death but not res	ulting in the un	derlying cause giv	en in Part I.		obacco use co Yes 2 1 No		e cause of death?
al Records,		Completed						24a. Was auto perfo	an 24b psy prmed? 22 No	prior to com death?	sy findings available pletion of cause of
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ō	Jing After fune	ation: To	27. Mapner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 ☐  28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injur	at wursing	Home 5 Resi	dence 6 🗆 Ot how injury occu		
-	- 9	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	<i>'</i> )	•		City or For			
	To the Hospitel or within 24 hours af To the Funerel Di completely filled in	Medical	one)	ner: On the best of my knowner: On the basis of examinat and manner stated.	wledge, death tion and/or inve		pinion, dodan oo	ce, and due to the curred at the time,	cause(s) and m date and place	anner as star , and due to t	ted. he cause(s)
	wit T o		29b. Signature and title of certifier	1 Comment	01	29c. Licenso	number	2	29d. Date sign	ed (Month, Da	ay, Year)
	1	-	30. Name and address of person who co	mpleted cause of death (Item	23a) (Tyne P	rint)	10/	/	June	42	2009
			Francis X. Carm				ve, Ba	ltimore	, MD 2	1204	
	Sta Registr		31. Date filed (Month, Day, Year)  JUN 2 9 2004	32. Registrar's Signat		backs				·	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM #5 PER EH G833 7/14/0/ JH State of Maryland Department of Health and Mental Hygiene 1- State of Mary taried / Department of Fleath of Peath Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death GERARD WILLIAMS Physician Day RRARD 4:25 P M WILLIAMS 24 /Medical 2504 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death NORTH WEST BALTIMORE SPITAL RANDALLSTOWN 110 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07. 23 1962 7. Age (In yrs. last birthday)
Yrs. Birthplace (State or Foreign Country) 2155874×12386 10KM 20 F MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits NIA Funeral Director Mo BALTIMORE 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 5602 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Be Completed by Specify: BLACK 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BARBER 11 TH GRADE NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) GEORGE WILLIAMS, SR VIVIAN WISE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LAVERA WILLIAMS 3713 W. MULBERRY ST. BALTO. MO 21929 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 1 4 □ Donation 5 □ Other (Specify) 06-30-04 LOUDON PARK BALTIMORE 21. Signature of Funeral Service Licen VAUGHN C. GREENE FUNERAL SER. 5151 BALTO. NATL PIKE, BALTO. NO angi 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PULMONARY EMBOLISM disease or condition resulting in death) Due to (or as a consequence of) VENOU HROMBOSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last NEPHROTIC Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? FAILURE 1 Yes 2 No 3 Probably 4 Nonknown 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one)

Priysician /Medical Examiner

permit. Page Department o Important: If any injury or once.

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Health and Mental Hygiene. ant: If item 27 is marked othar than "natural", or Itams 23a or 28a-f show ury or othar traumatic avant, the Medical Exercites I was be redified at

21215-0036

Maryland

Baltimore,

burial-tran attending physician

Examiner Physician/Medical ģ Completed Be 2

Certification:

After after death.

I Diractor: Af
d in by the fur To the Rospital within 24 bours a To the Furteral D

or Attanding Physician: The law requires that the death certificate be executed

P.O.

Division of Vital Records,

Medical State Registrar

examiner' 1 ☐ Yes 2 ☑ No 27. Manner of Death 1 Natural 2 Accident 3 🗌 Suicide 4 Homicide

29a. Certifier (Check only one)

investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

1-□Impatient 2□ER/Outpatient 3□ DOA 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Cortifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number D0059107 29d. Date signed (Month, Day, Year) 06-24-2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UMA, MD

LIBERTY MEIGHTS AVENUE BALTIMORE, MO 21215

31. Date filed (Month, Day, Year) JUN 2 9 2004.

29b. Signature and title of certifier

WESTSIDE MEDILAL 32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 11:30P M June 28 2004 Waldron Agnes Louise /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Manor Care - Towson Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea April 20, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5 Social Security Number **Funeral** Year) Days Hours Min 1 □ M 2 T F 1934 Virginia 70 Director 214-30-1737 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 28e-1 show 10d. Inside City Limits 10a State 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28e-f show other traumatic event, it a Modical Examiner must be notified at 1 ☐ Yes 24 No Director Maryland Cockeysville Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number United States 10535 York Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Pace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. MXYes 2 □ No Navy If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Insurance Brokerage Administrator 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ruth Thompson Waldron Harvey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important: If item 27 is
any injury or other trau 2300 Ellen Avenue Baltimore, Maryland 21234 Lillian Edwards - Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition June D30, 1 ☐ Burial 2 ☑Cremation 3 ☐Removal from State Metro Crematory 2004 Catonsville, Maryland 5 Other (Specify) 4 ☐ Donatio 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Kirkley-Ruddick Funeral
421 Crian Highway S.E. Home P.A. 21061 Glen Burnie, Maryland Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. Immediate Cause (Final disease or condition resulting in death) Me tas Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of) Box 68760, the attending physician Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year jo Day 4☐ Pregnant at time of death 5 ☐ Other (specify) P.O. be detached 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 Onknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2□ No 2 No 1 Yes Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Hospital or Attending Pl 24 hours after death.
 Funeral Diractor: After the Certification: Injury Natural 5 Pendina 2 No 1 Tyes investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 \ Homicide within 24 hours a To the Funeral C 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Madical E) Mininer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of cepitier my 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) reens Uman 112 22. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar JUN 2 9 2004

			i icasc	State of Maryla				Mental Hygie		
		1	1 - State RegistrarAMEND ITEM			nificate of	Death		N2004	20492
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	Physicia /Medic		LOUISE A		WIL	LIAM	>	JUNE	28 2009	
	Examin		4a. Facility Name (If not institution, give	11 = -			r Location of Death	1	4c. County of Deat	h Ala
		č.	5. Social Security Number with 6. S		s. last birthday)		T   M 0	9 Date of Birth	9 Rint	hptace (State or Floreign
	Funeral Director		1	M 2DF	Yrs.	Months Days	Hours Min.	(Month, Day, Y	co Co	intry) LA
			434-12-8628 Usual Residence of Decedent					Care Carri		
	anylan show	Ļ	10a. State 10b. County	10c. 0	City, Town or L	ocation				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	28a-f	Director	10e. Street and Number	10 11	Kur	10f. Zip Code		100	. Citizen of What Co	
	within 72 hours after death with the Maryland ene. Itan "natural", or itams 23a or 28a-f show Ita Mudical Evanitar must be notiliad at	ă	1.707 Fox Mac	don Roma	1	Toi. Zip Godo	21200	)	ISA	
	death	Funeral	11. Marital Status	12. Was Decedent Ever in	U.S. 13.	Was Decedent of H	lispanic Origin? (S	pecify Yes or No-	14. Race - Ame	
ထ	or ita	Fur	1 Never Married 2 Married	Armed Forces?  1 Yes 2 No If Yes, Give		1 ☐ Yes 2 ☑ No	an, mexican, Puen Specify:	o Alcan, etc.)	Specify: 0	e, etc.
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212	withi	Completed	Elementary/Secondary (0-12)	Cotlege (1-4or 5+)	(	Seams	tress			(unknown)
פ	ould be filed with Mental Hygier arkad othar thatic evant,	Be C	17. Father's Name (First, Middle, Last,	1 11			18. Mother's Nar	ne (First, Middle, Ma	aiden Sumame)	
<u>Na</u>	should b and Menta markad umatic e	To	Henei M. N	IIIIams_			Loui	se be	aurega	RD
Maryland	2 sho		19a. Informant's Name/Relationship (	Type, Print)	19b. Mail	ing Address (Street	and Number or Ru	iral Route Number, C	City or Town, State, 2	Zip Code)
	1 and 1 Health		20a. Method of Disposition	20b	. Place of Disp	osition (Name of	LIMAGO	Date 20	Dc. Location - City or	Town, State
nor	Pages nent of I int: If its ury or o		1 D Burial 2 □ Cremation 3 □ 1 □ Cremation 3 □ 1 □ Cremation 3 □ Cremation 3 □	Removal from State	Cemetery, cre	matory or other pla	(ce)	NI 0	allinno	mo.
altimore,	그 든 합 등		21. Signature of Funeral Service Lice	A	7/04	2. Name and Addre		ugha Gri	eene Fun	ral Service
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			23a. Part1. Enter the dilea le, or com shock, or heart fail ille List only	plications that caused the de one cause on each line.	eath. Do not en	ter the mode of dyir	ng, such a cardia	or respiratory arres	t,	Approximate Interval Between
	Physician		tmmediate Cause (Final disease or condition	a ASPIR	CATIC	N	PNEU	MONIA		Onset and Death
Ţ.	/Medical Examiner		resulting in death)	Due to (or as a cons	equence of):					
		5	Sequentially list conditions,	b. Due to (or as a cons	equence of):					
	uted 1 ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
ó	te be executed ysician and e buriat-transit		resulting in death) Last	Due to (or as a cons	equence of):					
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89 >	that the death certifical ed by the attending phi detached for use as th	Physician/Med	IF FEMALE:	00 16				-	1111	10-1-11-11-1
Вох	attend for us	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pred 1 Live birth 2 Fe 4 Pregnant at time o	etat death 3	□Ectopic pregnanc	у		23d. Date of del Month	ivery Day Year
o	the de	iysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown	a death of	_ Other (specify) _				
۵.	The law requires that the death certifica tie has been signed by the attending phoage 2 should be detached for use as the		Part II. Other significant conditions	contributing to death but not r	resulting in the	underlying cause giv	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
rds	w requires been sign should be	ed b	CONGESTIVE	HEART	FAIL	ure		1 ☐ Yes	2 □ No 3 □ Pr	obabiy 4 Onknown
Records,	ie law requ has been ge 2 shouli	plet	RENAL F.	ALLUPE				24a. Was an autopsy	prior to o	stopsy findings available completion of cause of
Œ.		Completed by	HYPERTENS	IVE CARL	DIO VAS	CULAR	DISEAS	performe 1 ☐ Yes 2		2 No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		0#		ath (Check only one)		
of	Phys this ral dii	- To	1 ☐ Yes 2 ☑ ★ 0	1 Inpatient 2				lome 5 Residen 28d. Describe how	ce 6 Other (Spec	cify)
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Division	l or Attandii after death. Director: Ai I in by the fu	Certification:	3 Suicide 6 Could not be determined		t home, farm, s	treet, factory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	ural Route Number,
	tal or rs afte al Dir	Cert		Building, sto. (eps						
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	edical	(Check only 2 Medical Exe	hysicien: To the best of my k miner: On the basis of exam						
	To tha within 2 To tha complet	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. Licens	se number	290	d. Date signed (Monti	h, Day, Year)
	F 3 F 3		1 Tomes	en mol		DZ	0272		TUNE 26	2004
			30. Name and address of person who	completed cause of death (I	tem 23a) (Type		- 2 1 4		BALTIME	,/
	\				7	Ecoups	HOS	PITAL	BALTIME	me, MD.
	Sta Regist	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sig	gnature	1000				

Maryland Baltimore   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dundalk   Dun			State of Maryland / Del 1- State AFEND ITEM #27 PER PRY G832 6	partment of Health and Merificate of Death		ne №2 () () ( ₄	20493
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Medical Examiner    Sequentially list conditions if any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to immediate any, leading to im			disease or condition				Onset and Death
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25. Was case referred to medical examiner?  1		ysiclan/Med	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3				
25. Was case referred to medical examiner?  1   Yes   2   No	rds, P.	by	HTN, hyperlipidemia, diabetes,	commany		,	
27. Manner of Death  28a. Date of Injury  28d. Describe how injury occurred  Work?  2 Accident  2 Accident  2 Pending  2 Pending  2 Accident  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2	Reco	complete	artery disease, renal failur	e	autopsy performed	death?	
27. Manner of Death  28a. Date of Injury  28d. Describe how injury occurred  Work?  2 Accident  2 Accident  2 Pending  2 Pending  2 Accident  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2 Pending  2	/ita		evaminer?		(Check only one)		
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2 2 to 1 to 2   Accident presugation	ing ing	lon:	1 Latural 5 Pending (Month, Day Year) Injury	y Work?	28d. Describe how i	njury occurred	
	SiG Seath	cat	3 Suicide Sepuld not be ago Place of Injury - At home form		28f. Location (Stree	t and Number or Ru	ral Route Number.
Description of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of th	Div A atter Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Dire	ertif	4 Homicide determined building, etc. (Specify)	stroot, factory, office			
281. Location (Street and Number of Hural House Number)  282. Location (Street and Number of Hural House Number)  283. Location (Street and Number of Hural House Number)  284. Location (Street and Number of Hural House Number)  285. Location (Street and Number of Hural House Number)  286. Place of Injury - At home, farm, street, factory, office  287. Location (Street and Number of Hural House Number)  288. Location (Street and Number of Hural House Number)  289. Place of Injury - At home, farm, street, factory, office  281. Location (Street and Number of Hural House Number)  281. Location (Street and Number of Hural House Number)  281. Location (Street and Number of Hural House Number)  281. Location (Street and Number of Hural House Number)  282. Location (Street and Number of Hural House Number)  283. Location (Street and Number of Hural House Number)  284. Location (Street and Number of Hural House Number)  285. Location (Street and Number of Hural House Number)  286. Place of Injury - At home, farm, street, factory, office  287. Location (Street and Number of Hural House Number)  288. Location (Street and Number of Hural House Number)  288. Location (Street and Number of Hural House Number)  289. Date and place, and due to the cause(s) and manner as stated.  290. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  290. Date signed (Month, Day, Year)	e Hospite 24 hours e Funerel		(Check only 2 Medical Examiner: On the basis of examination and/or	ath occurred at the time, date and place, investigation, in my opinion, death occurr	and due to the caus ed at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year)	To th Withir	Me	29b. Signature and title of certifier				
23014 June 20,2004			CARMO	23014	Ju	me 20,7	2004
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Rani Rosborough 4940 Eastern Ave Baltimore, MD 21224	511		Rani Rosborough 4940 Eastern	e. Print)  1 Ave Baltimore	, MD 2	1224	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature 111N 2 9 2004			31. Date filed (Month, Day, Year) 32. Registrar's Signature	doorker			

	For Stete Registrer	State of Maryland		rtment of He rificate of D			iene _{99. No} 2 () ()	4 201.91
Physician /Medical	Decedent's Name (First, Middle, L     Mary	Shirley		Walker		2. Date of Death Month	Day Y	3. Time of Death 004. 0345 AM
Examiner	4a. Facility Name (If not institution, g	ive street and number Hospi	tol		none City			JA
Funeral Director	216-34-8289	Sex 1 □ M 2 F 7. Age (In yrs. I	last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	B. Date of Birth (Month, Day, 12–27–	Year)	O. Birthplace (State or Foreign Country) West Va.
tat	Usual Residence of Decedent  10a. State 10b. County	10c. City	y, Town or Loc					10d. Inside City Limits
be notified be notified Director	Md. NA  10e. Street and Number		Balti	10f. Zip Code		11	0g. Citizen of Wh	at Country?
t be r	905 Bayard Stre	et		2122	23		USA	
Examination 23a or 28a-1 show Examination out the notified at	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces?		ras Decedent of His Yes, specify Cubar ☐ Yes 2 No	spanic Origin? (Spec n, Mexican, Puerto R Specify:	ify Yes or No- ican, etc.)	Black,	American Indian, White, etc. Black
ner than "natural", it, the Mudical Exu Completed by	15. Decedent's (Specify only highest of	grade completed)	(Give k	ent's Usual Occupa ind of work done d O NOT use retired,	uring most of working	9	16b. Kind of Busi	ness/Industry
than the M	12th grade	College (1-4or 5+)	Ca	fateria			Hospita	
4 6 5 T	17. Father's Name (First, Middle, La				18. Mother's Name			
traumatic ev	Benjamin McCorn		19b. Mailing	Address (Street a	ind Number or Rural	de Run		ate, Zip Code)
V =	Vanae Walker	Daughter	905	Bayard St	., Baltim	ore, Mo	. 21223	3
Important: If Item 2 any injury or other once.	20a. Method of Disposition  1   ↑ Burial 2 □ Cremation 3  ↑ 4 □ Donation 5 □ Other (Spe	☐Removal from State	Place of Dispos semetery, crem . Carm	atory or other place	₉₎ 6–26		20c. Location - C Dundal	
Important: any injury once:	21. Signature of Funeral Service Lic	ensee Ware		Name and Addres			more, Mo North Av	
physician and the burlat-transit apply the burlat-transit and and apply the burlat-transit and apply the burlat-transit and and apply the burlat-transit and and apply the burlat-transit and and apply the burlat-transit and and apply the burlat-transit and and apply the burlat-transit and and apply the burlat-transit and and apply the burlat-transit and and apply the burlat-transit and and apply the burlat-transit and and apply the burlat-transit and apply the burlat-transit and apply the burlat-transit and apply the burlat-transit and apply the burlat-transit and apply the burlat-transit and apply the burlat-transit and apply the burlat-transit and apply the burlat-transit and apply the burlat-transit and apply the burlat-transit and apply the burlat-transit and apply the burlat-transit and apply the burlat-transit and apply the burlat-transit and apply the burlat-transit and apply the burlat-transit and apply the burlat-transit and apply the burlat-transit and apply the burlat-transit and apply the burlat-transit and apply the burlat-transit and apply the burlat-transit and apply the burlat-transit and apply the burlat-transit and apply the burlat-transit and apply the burlat-transit and apply the burlat-transit and apply the burlat-transit and apply the burlat-transit and apply the burlat-transit and apply the burlat-transit and apply the burlat-transit and apply the burlat-transit and apply the burlat-transit and apply the burlat-transit and apply the burlat-transit and apply the burlat-transit and apply the burlat-transit and apply the burlat-transit and apply the burlat-transit and apply the burlat-transit and apply the burlat-transit and apply the burlat-transit and apply the burlat-transit and apply the burlat-transit and apply the burlat-transit and apply the burlat-transit and apply the burlat-transit and apply the burlat-transit and apply the burlat-transit and apply the burlat-transit and apply the burlat-transit and apply the burlat-transit and apply the burlat-transit and apply the burlat-transit a	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conseq b. Due to (or as a conseq c. Hyperth Due to (or as a conseq d. Chronic	uence of):	lism	boi Nati	`m		yn yn
be detached for use as by Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pregns 1 □ Live birth 2 □ Fete 4 □ Pregnant at time of d 9 □ Unknown	oldeath 3□	Ectopic pregnancy Other (specify)			23d. Date Monti	
signed by the attendin d be detached for use d by Physiclan/N	Part II. Other significant condition	s contributing to death but not res	sulting in the un	derlying cause give	en in Part I.			ute to the cause of death?
cate has been si page 2 should I						24a. Was a autops perform	sy pri med? de	ere autopsy findings available or to completion of cause of ath?  Yes 2 No
within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as more recording tilled in by the funeral director, page 2 should be detached for use as Medical Certification: To Be Completed by Physician/Med	25. Was case referred to medical examiner?	Hospital:	TER/Outpotion	Oth	26. Place of Death er: 4 ☐ Nursing Hom			(Specific)
aral dire	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	3 DOA 28c. Injun Worl	at 2		ow injury occurred	
within 24 nouts after documents centificate has completely filled in by the funeral director, page 2 medical Certification; To Be Comp	1 Natural 5 Pending 2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	tion	ome, farm, str	M 1 🗆	Yes 2□No	8f. Location (Si City or Town		or Rural Route Number,
thin 24 hours the Funeral mptetely filler Medical C	29a. Certifier 1 Certifying (Check only one)	Physicien: To the best of my know eminer: On the basis of examina and manner stated.	owledge, death ation and/or inv	estigation, in my o	pinion, death occurre	d at the time, d	late and place, an	d due to the cause(s)
To the comple	29b. Signature and title of certifier	and		29c. Licens	e number 4 97 4		une, 2	(Month, Day, Year)
1	30. Name and address of person w	ho completed cause of death (Item, MD, 60), SOU	m 23a) (Type, th Cha	Print) Les St	reet, Ba	Himos	re, MD	21230
	31. Date filed (Month, Day, Year)	2. Registrar's Sign						

DHMH 17 Rev 1/2001

MANY S. Walker

			State of Maryland / Department of Health and Mental Hygiene  1 - State Registrer  Certificate of Death  Reg. No.?
	Physici		1. Decedent's Name (First, Middle, Last)  HANSELL WILLIAM SUN  2. Date of Death Month Day Year Type 20 2004 5:55 PM
7	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death  ALTIMORE VA MEDICALCTR BALTIMORE
	Funeral Director		5. Social Security Number 414-20-5199  6. Sex 1 Months Days Hours Min. 1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Nov 17, 1923  1 Months Days Hours Min.  1 Month, Day, Year)  1 Nov 17, 1923  1 Months Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  1 Month, Days Hours Min.  2 Month, Days Hours Min.  2 Month, Days Hours Min.  2 Month, Days Hours Min.  3 Month, Days Hours Min.  3 Month, Days Hours Min.
	ith the Maryland or 28a-f show	or	10a. State MD Harford 10c. City, Town or Location 10d. Inside City Limits Aberdeen 1 □ Yes 2√□ No
	or 28a-	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
36	within 72 hours after death with the Maryland ene. than "naturel", or items 23a or 28a-f show the Madicul Exar di act must be indiffed at	by Funerai	706 Maxa Road  11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Amed Forces? 1 ☐ Yes 2 ☒ No Specify: 1 □ Yes 2 ☒ No Specify: 1 □ Yes Specify: White
Maryland 21215-0036	within 72 hours ene. than *naturel', ne Wedicul Ex	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  17b. Kind of Business/Industry  17b. Kind of Business/Industry
/land 2	be filed ital Hygi id other event, I	To Be Co	12 U. S. Army  17. Father's Name (First, Middle, Last) Cecil B. Williamson  U. S. Army  18. Mother's Name (First, Middle, Maiden Sumame)  Jennie Bailey
Man	nd 2 should th and Mer 27 Is marke r traumatic		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Elizabeth Williamson/spouse  706 Maxa Road Aberdeen, MD 21001
Baltimore,	Pages 1 and 2 ment of Health ant: If item 27 I ury or other tra		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, State
Balt	permit. Pag Department Important: I any injury o		21. Secretario of Euneral Service Incensee 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201
1	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to for as a consequence of):  Approximate Interval Between Onset and Death (4 Wee/C
8760,	ate be executed hysician and the burial-transit	dical Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C.  Due to (or as a consequence of):  d.
P.O. Box 68	The law requires that the death certific, the has been signed by the attending plage 2 should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1
rds, P	w requires that been signed k should be det	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  239. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown
Division of Vital Records,		Completed	ANEMIA OF Chranic Disease.  24a. Was an autopsy performed?    Disease   1   Yes 2   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2   Yes   1   Yes 2   Yes   1   Yes 2   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes   Yes
f Vita	Physicien: Th r this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1  Yes 22 No  Hospital: 2 ER/Outpatient 3 DOA  Other: 4 Nursing Home 5 Residence 6 Other (Specify)
sion o	ding P. Afte fune	Certification;	27. Manner of Death  1
Divi	Ital or At rs after d el Direct led in by	Certifi	28e. Place of Injury: At home, farm, street, factory, office determined determined determined building, etc. (Specify)  28e. Place of Injury: At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or Attenwithin 24 hours after deal To the Funeral Director: completely filled in by the	ledical	29a. Certifier  (Check only one)  12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	To To	×	29b. Signature and title of certifier  29c. License number  Av 4186435 15232  29d. Date signed (Month, Day, Year)
			30. Name and address of person to completed cause of death (Item 23a) (Type, Print)  Dose Green Sform D 10 NORTH Green Street Baltimore my 2201
	Sta Registr	_	31. Date filed (Month, Day, Year) 732. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Yarcus /Medical JUNE 2.5 2004 4a. Fecility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Deeth GREATER BALTIMORE MEDICAL CTR TOWSON

If Under 1 Year | If Under 24 Hrs. BALTIMORE 8. Date of Birth Month, Day. **Funeral** 6. Sex, 1 X M 2 ☐ F 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) Days Yrs. Director UNKNOWN Usual Residence of Decedent death with the Maryland 10b. County worde! 10a, State 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Be Completed by Funeral Director ORK 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7403 YORK or items 23a Blan 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 22 No if Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Never Married 2 Married Maryland 21215-0036 1□ Yes 2 No 3 Widowed 4 Divorced Black 'netural' 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Intant 17. Father's Name (First, Middle, Last) 2 should be finance in and Mental H 18. Mother's Name (First, Middle, Maiden Sumame Pages 1 and 2 should ar 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Typ Print) if item 27 i 17/40COU) 2/204 6701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) permit. Page Depertment of Important: If any injury or 2005 injury or CREEN MOUNT (REMARCY 21. Signature of Funeral Service License 22. Name and Address of Facility 6924 Jork 10 1 ESSIAMI 1 Tookton 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** EXTREME PREMATURITY disease or condition resulting in death) minutes /Medical Due to (or as a consequence of): **Examiner** CHORIOAMNIONITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): to the Hospitsi or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Day 4☐Pregnant at time of death Year 5 ☐ Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? res 2 No 1 Yes 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☒ No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of ath 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 50546

Registrar
DHMH 17 Rev 1/2001

State

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31. Date filed (Month, Day, Year)

JUN 2 9 2004

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ted cause of death (Item 23a) (Type, Print)

Treet,

32 Registrar's Signature

A Partie

			State of M  State of M  State of M  PER FH		epartment	of Health and N of Death		ene			
			Decedent's Name (First, Middle, Last)				2. Date of Death Month		3. Time of Beath		
	Physicia /Medic		FREDERICK	W	DBBEI	KING	JUNE	23 200	4 6:37AM		
•	Examin		4a. Facility Name (If not institution, give street and number,	1		own, or Location of Death	1	4c. County of Dea	th		
Н			Bon Secours Hospital  5. Social Security Number 6. Sex 7. Av	no (In use last histh		imore Year   If Under 24 Hrs.	9 Date of Birth	0.0	theless (Otate or Formion		
	Funeral Director		5. Social Security Number 212-09-8015 6. Sex 12 - 09 - 8015 7. Age (In yrs. last birthday) 15 - 16 - 17 - 18 - 18 - 18 - 18 - 18 - 18 - 18				Year) 1911 Mar	thplace (State or Foreign ountry) yland			
	land ow	tor	10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits		
	Mary F-f sh		Maryland Baltimore	Cat	tonsville	е			1 □ Yes 22□No		
	or 28s	Director	10e. Street and Number		10f. Zip C	Code	10	g. Citizen of What C	ountry?		
	23a		3 McIntosh Court			21228		U.S.A.			
9	n 72 hours after death with the Maryland "natural", or Items 23e or 28e-f show videal Extr. ther must be notified at	Completed by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Armed Forces  1 □ Yes 2 ☑ If Yes, Give Year or Dates:	INo		nt of Hispanic Origin? (S _I y Cuban, Mexican, Puert ☑ No <i>Specify</i> :	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Whi			
5-0036	2 hours		15. Decedent's Education		Decedent's Usual (	Occupation	1	6b. Kind of Business			
<del>دا</del> 2	within 72 ene. than "nat		(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or	5+)		Occupation done during most of work retired)			-		
7	filed wit Hygiene Ather the		12th Grade		lachinist			rown, Cor	k & Seal		
	d tal	Be	17. Father's Name (First, Middle, Last)				ne (First, Middle, M.	laiden Sumame)			
<u> </u>	ould Men narke	^L	Aldolph Wobbeking	10h 1			Clara Link d Number or Rural Route Number, City or Town, State, Zip Code)				
Maryland	d 2 sh th and 7 Is n traun		19a. Informant's Name/Relationship (Type, Print) Otha Louise Wobbeking (Wif			Court Cator		100			
	s 1 and f Health item 27 other to		20a. Method of Disposition	20b. Place of D	Disposition (Name	of		Oc. Location - City of			
ē	Pages nent of nnt: If it ury or o		1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State  1 ☐ Donation 5 ☐ Other (Specify)	•	, crematory or othe Jash Cren	natory 6-26	5-2004	Laurel, M	arvland		
Baltimore,	permit. Pages Department of H Important: If its any in ury or of once.		21. Signat Fune at Sovice Licensee		22 Name and	Address of Facility			-		
ñ	P P P P P P P P P P P P P P P P P P P		Moi	290	1630 Edn	Funeral Home mondson Aver	nue Caton	nsville, M sville, M	inc. 21228		
	Pnysician		23a. Part1. Enter the disease, or complications that cause shock, of heart failure. List only one cause on each immediate Cause (Final	line.	•	of dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death		
	/Medical		Immediate Cause (Final disease or condition resulting in death)  PNUEMONA  Due to (or as a consequence of):						1 11/2		
	Examiner	er	if any, leading to immediate	s a consequence of	Je .	ACTIVE L			UNENUW		
	ate be executed hysician and the burial-transit	Examiner	Cause. Enter Underlying Cause (Disease or injury  ARTERIOSC 1 TROTIC 14EART D1SF					EASE	44		
Ö,	e exe ian a urial-t		resulting in death) Last  Due to (or as a consequence of):  PENAL INSUFFICIENCY						Ł		
8760	cate b	dlcal	d	ENAL	71000	FFICIEN	<u></u>				
Box 6	death certificate be executed te attending physician and ad for use as the burial-transit	Physiclan/Me		e of pregnancy 2 Fetal death at time of death	3 ☐ Ectopic preg			23d. Date of de Month	livery Day Year		
o.	t the de by the tached	hysi	9 Unknown 9 Unknown								
Records, P.	signed signed d be de	by	Part II. Other significant conditions contributing to death	II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contributing to Part I.  1 Yes 2 No 3					o the cause of death?		
000	aw requ s been 2 shoult	Completed					24a. Was an		utopsy findings available		
	The fa	mo:					autopsy performe		to completion of cause of 1? 'es 2 No		
Vital	sician: The law certificate has irector, page 2 s	Be C	25. Was case referred to medical examiner?			26. Place of Dea	th (Check only one	-1			
	Physic this ceral dire	၉	1 ☐ Yes 2 ♠ No Hospital: 1 🗷 Inpat		patient 3 DOA			nce 6 Other (Spe	cify)		
n	ding P th. After t funera		27. Manner of Death 1 ★Natural 5 □ Pending (Month, D.	ury 28b. Tin ay Year) Inji		c. Injury at Work?	28d. Describe how	v injury occurred			
<u>s</u>	Attending Physician: or death. ector: After this certification in the funeral director.	Icat						et and Number or R	ural Route Number		
Division of	Ital or Attend ins after death ral Director: , lled in by the f	Medical Certification:									
	To the Hospital or A within 24 hours after To the Funeral Directompletely filled in b.		29a. Certifier  (Check only one)  1A Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	To the To the Comp		29b. Signature and title of certifier 29d. Date signed (Month, L					h, Day, Year)			
1	. (		- Salow	MD		D 23300		JUNE	23 2004		
	15		30. Name and address of person who completed cause of	death (Item 23a) (T	ype, Print)	BON 352 BALTO	UNR3	HOSP.	00		
			SUDICIR D PA  31. Date filed (Month, Day, Year)  32. Regist	trar's Signature	A PO WI	130210	51 /	DN-LID )	40, 21223		
	Sta Registr		11IN 9 9 2004 Peners	· A	looks to	•					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 20,2004 **Physician** Year 15:30 ™ BERNICE LORRAINE AMOS JUNE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 4795 FORD COURT WHITE PLAINS CHARLES | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | APR • 28, 1924 | WASH • , D • C • Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Months 80 Yrs. 578-20-7699 **Director** Usual Residence of Decedent •how 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itams 23a or 28a-f show the Medical Exeminer must be notified at 1 ☐ Yes 2 No MARYLAND CHARLES WHITE PLAINS Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4795 FORD COURT 20695 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 27 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 Yes XXNo Specify: þ If Yes, Give Year or Dates: Specify: WHITE 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. HOMEMAKER OWN HOME 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be fi h and Mental H 7 le marked ott Be ROLAND PERRY MARY MOSHER 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 le rany injury or and 14009 WOODWELL TER. SILVER SPRING, MD. 20906 RONALD G.AMOS-SON Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o CEDAR HILL CEMETERY 6-24-04 SUITLAND, MARYLAND MO0479 21. Signature of Funeral Service Licensee RAYMOND FUNERAL SERVICE, P.A. PLATA, MARYLAND 20646 reha 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) areles mys **Physician** chemic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed physicien a s the burial-1 Due to (or as a consequence of): P.O. Box 68760, Physiclan/Medlcal as IF FEMALE use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ been sig 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? page 1 Yes 2 No Be ( 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient Other: 4 Nursing Home 58 Residence 6 Other (Specify) 1 Yes 2 J-No 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c, Injury at Work? Certification: 28d. Describe how injury occurred After or Attending 1 @Natural 5 Pending after death. Director: Af м 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral E Hospital 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ughnRD 332 32. Registrar's Signature State Registrar

			1- For AMEND ITEM 24A State of Maryland Department of Health and Certificate of Death	Mental H	ygiene	201.00
	Physici	an	Decedent's Name (First, Middle, Last)	2. Date of D	eath	3. Time of Death
d	/Medi	cal	Robert Louis Angelini	LIUNE		
	Examir	ner	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Dea		4c. County of D	Peath
	Funeral		5. Social Security Number 6. Sex J 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs	S. A. Date of B.	Harto	Birthplace (State or Foreign
	Director		218-26-3031 1♀ Nonths Days Hours Min		8, 1932	Country) Pennsylvania
	pug *		Haust Pasidanas of Pasadant	<i>*</i>		
	h the Maryland r 28a-f show	ō	MD Harford Havre de Grace			10d. Inside City Limits 12€ Yes 2 □ No
	28a-	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What	
	23a or	ai Di	553 Congress Avenue 21078		U.S.	
	r dea	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (5 ff Yes, specify Cuban, Mexican, Puer	Specify Yes or N	o- 14. Race - A Black, W	merican Indian,
36	rs afte	by Fu	1 □ Never Married 2 ☐ Married 1 ☑ Yes 2 □ No If Yes, Give 1 □ Yes 2 ☒ No Specify: Year or Dates: Korea		Specify: W	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland Ital Hygiene. d other than "naturel", or items 23a or 28a-f show event, Ital Medical Examiner must be neitified at	ted t			16b. Kind of Busine	
215	d within 72 h giene. r than "natu	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupetion (Give kind of work done during most of wo	orking	Tob. Time of Basine	ounday
2	a filed wi Il Hygien other th	Con	12 0 Civil Service		U.S. Gover	mment
and	be fill Hall Hall Hall Hall Hall Hall Hall H	Be			e, Maiden Sumame)	
Ž	2 should be to and Mental if in marked of raumatic every	ဥ	Philip Angelini Emma  19a. Informant's Name/Relationship (Type, Print)  19b. Maifing Address (Street and Number or Ri	Casaldi		7-0-4-
	ges 1 and 2 should be filed to fleath and Mental Hyg If item 27 is marked othe or other traumatic event,			Havre de	e Grace, M	21078
ore,	os 1 and 2 of Health item 27 i		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Dete	20c. Location - City	or Town, State
Ë	Page ment c ant: if		1325 urial 2 □ Cremation 3 □ Removal from State 14 □ Donation 5 □ Other (Specify)  Highview Mem. Gdns. 6/19	/04	Fallston,	MD
Baltimore,	permit. Pages to Department of the Important: if ite any injury or of once.		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Tarring-Cargo Funeral Service Licensee  Aberdeen, Maryland	neral Ho	ome, B.A.	
			3a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardial			Approximate
	Physician		shock, or heart failure. List only one cause on each line.  Immediate Cause (Finel disease or condition  CEREBIOLABILAR	AARIN	ENT.	Interval Between Onset and Death
7	/Medical		resulting in death)  Due to (or as a consequence of):	NO UINC	700 /	
	Examiner		Sequentially list conditions, b			
	led sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
	axecul	Examiner	that initiated events resulting in death) Last   Due to (or as a consequence of):			
,8760,	cate be executed physician and the burial-transit	dicai	d			
9	rtificating physical results	Medi	IF FEMALE:			
Вох	law requires that the death certifi as been signed by the attending I 2 should be detached for use as	by Physician/Me	23b. Was decedent pregnant in the cast 12 months?   23c. If yes, outcome of pregnancy   1 □ Live birth   2 □ Fetaf death   3 □ Ectopic pregnancy		23d. Date of o	•
P.O. I	he dea the a	ysic	1		Month	Day Year
ď.	res that thigh and the igned by be detact	/ Ph	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did t	obacco use contribute	to the cause of death?
Division of Vital Records,	quires n sign	q pe		1		Probably 4 Unknown
000	aw rek Is bee 2 shor	Completed		24a. Was	an 24b. Were	autopsy findings available o completion of cause of
I Re	ricien: The lav certificate has rector, page 2	E O		autor perfo	mean death	completion of cause of es 2 No
/ita	ding Physicien: The In. After this certificate ha	Be		ath (Check only o		2 140
of \	Physic this c	2	1 ☐ Yes 2 ☐ Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Wursing H		dence 6 □Other (Sp	pecify)
on	ding f h. After funer	tion	1 Neural 5 Pending (Month, Day Year) Injury Work?	28d. Describe h	now injury occurred	
<u>Visi</u>	Atten r deat sctor; by the	ifica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office	28f. Location (5	Street and Number or i	Rural Route Number.
ā	s afte	Certification;	4 ☐ Homicide determined building, etc. (Specify)	City or Tox	vn, State)	
		Medical (	29a. Certifier (Check only one)  Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	, and due to the cred at the time,	cause(s) and manner a date and place, and du	as stated. se to the cause(s)
	To the within Fo the comple	Me	29b. Signature and title of certifies 29c. License number		29d. Date signed (Mor	nth, Day, Year)
			10111		Calinlas	1.
	/		30. Name and address of person who completed cause of death (Item-23a) (Type, Print)	A MI	1 -11/109	7
	7		31. Date filed (Month, Day, Year) 32. Registrar's Signature	7 /14/	2/078	
	Stat Registra		JUN 2 9 2004 Service Signature			

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	a .		State of Marylai	•	ate of Death	Re	eg. No.	4 20	500
	nysician Medical	1. Decedent's Name (First, Middle, Last) Alice Ma		echie		2. Date of Deat Month Jun 22,	2004	Year 8:	Time of Death  50 pm
Fun	caminer	214-02-7901	ng Home		4b. City, Town, or  Cumberla  Jer 1 Year If Under 24 Hrs Is Days Hours Min	8. Date of Birth	Allega Year) 1916	any	(State or Foreign
Marylend f show	led.at	Usual Residence of Decedent  10a. State 10b. County  MD Allegany	10c. City, Town or Location Cumberland		ind			1	nside City Limits
th with the I	nner must be notified at Funeral Director	10e. Street and Number 14334 Old Lake Dri			Zip Code <b>21502</b>			n of What Country?	
ter dea items	<b>H</b>	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ※☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:		cedent of Hispanic Origin? (specify Cuban, Mexican, Puer 2XI No Specify:	Specify Yes or No- to Rican, etc.)	14. Rac Blac Specify	e - American Inck, White, etc.  white	dian,
within she.	or other treumetic event, the Medical Exp	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	16a. Decedent's U (Give kind of life. DO NO: Homemak	work done during most of wo use retired)	orking	16b. Kind of Bu	usiness/Industry	
Maryland 2 12 should be filed on Mental Hygis 18 marked other	atic event, To Be C	17. Father's Name (First, Middle, Last) William E. Clise			18. Mother's Na  Mary A	me (First, Middle, M	augh) C	lise	<u>.</u>
and 2 sho ealth end I	her traume	19a. Informant's Name/Relationship (Ty Thomas Bechie	son	14334 C	ess (Street and Number or R Ild Lake Dr SW	/ Cumbe	erland	MD 2	1502
Baltimore, No pendit. Pages 1 and Depertment of Health Important: If them 27	Injury or oth	20a. Method of Disposition  1   ☐ Burial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Sul	Place of Disposition (in commetery, crematory of the nset Memoria	Park	Date 6/24/2004	Cumbe	city or Town, S	MD
Baltin permit. P Depertme	eny In	21. Signature of Funeral Service Licensee  Scarpelli Funeral Home, PA  108 Virginia Avenue: Cumberland, MD 21502							
Physi Hwee Exam	nical niner	Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):							val Between et and Death
687 ificete	Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):  Due to (or as a consequence of):						
O B S	Physician/Me	Part II. Other significant conditions cor		sulting in the underlyin	g cause given in Part I.		bacco use cor es 2 <mark>₽ N</mark> o		cause of death?
/\ _ U	completed by Pl						24a. Was an autopsy performed?  24b. Were autopsy find available prior to completion of caus of death?		
of Vital Rec Physician: The law	rector D Be	25. Was case referred to medical examiner?	lospital:	☐ ER/Outpatient 3☐	Othor	ath (Check only on Home 5 ☐ Reside			2 □ No
Division of  Hospital or Attending Phys 1.24 hours effer death.  Funerel Director: After this	e e	27. Manner of Death  1	28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At building, etc. (Spec	28b. Time of Injury M	28c. Injury et Work?  M 1 Yes 2 No			ite Number,	
he Hospita n 24 hours e Funerel	lcai	29a. Certifier (Check only one)  12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							cause(s)
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